Setting- up a Micro Health Insurance Scheme
Relevancy, challenges and process

An introduction

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Précisions :

- *Relecture de cohérence non réalisée*
- *Commentaires de Valérie concernant le chapitre 1 non encore intégrés.*
- *Illustration de la diversité à renforcer - « Case study boxes » en cours*
- *Absence des annexes*

Introduction

The lack of social protection in health care affects nearly 80 per cent of the population in most countries of Sub-Saharan Africa and Southern Asia, and nearly half the population of Latin America and the rest of Asia. Persons excluded from social protection systems consist, for the most part, of informal economy workers and their families[1].

As social protection systems are nowadays subject to strong financial constraints, they are rarely able to extend their coverage to a wider section of the population. Therefore, efforts to extend social protection to "excluded persons" are essentially carried out through new and specially adapted mechanisms. Among the initiatives to provide coverage in the event of sickness to "uncovered persons", health micro insurance schemes have grown considerably in number during the last two decades. The term "health micro-insurance" encompasses a wide variety of schemes. These include: mutual health organizations, which are autonomous associations based on the solidarity and democratic participation of their members; insurance schemes, which are organized and managed by health care providers (a health centre or a hospital may offer its users a reduction in health expenses or access free-of-charge to certain health care services in exchange for the payment of a premium); health insurance schemes set up by other actors, such as NGOs, community-based organisations, microfinance institutions, cooperatives or trade unions.

The development of health micro insurance schemes is gaining increasing interest as one of the potential ways that might be invested to extend social protection to uncovered segments of the population in developing countries. There have been promising linkages between government programs and health micro-insurance schemes such as in India, Philippines and Lao. In addition partner-agents links are being developed between private insurers and community-based organizations, co-operative health insurance programs and many other models. Other regions of the world such as Africa (prevalence of mutual health insurance organizations) and Latin America have also experience a growth in the provision of health care coverage to the informal economy.

However, setting-up a health micro-insurance scheme may not be relevant in all contexts and is certainly not (alone) the panacea to protect the poorest segments of the population against catastrophic health expenditures and its associated risks of deeper decline into poverty. Besides, if relevant, setting-up a health micro-insurance scheme is definitely not an easy task as it requires mastering insurance technical features, standard management knowledge as well as contextual

[1] In this document, persons excluded from social protection systems will be referred to as "excluded groups" .

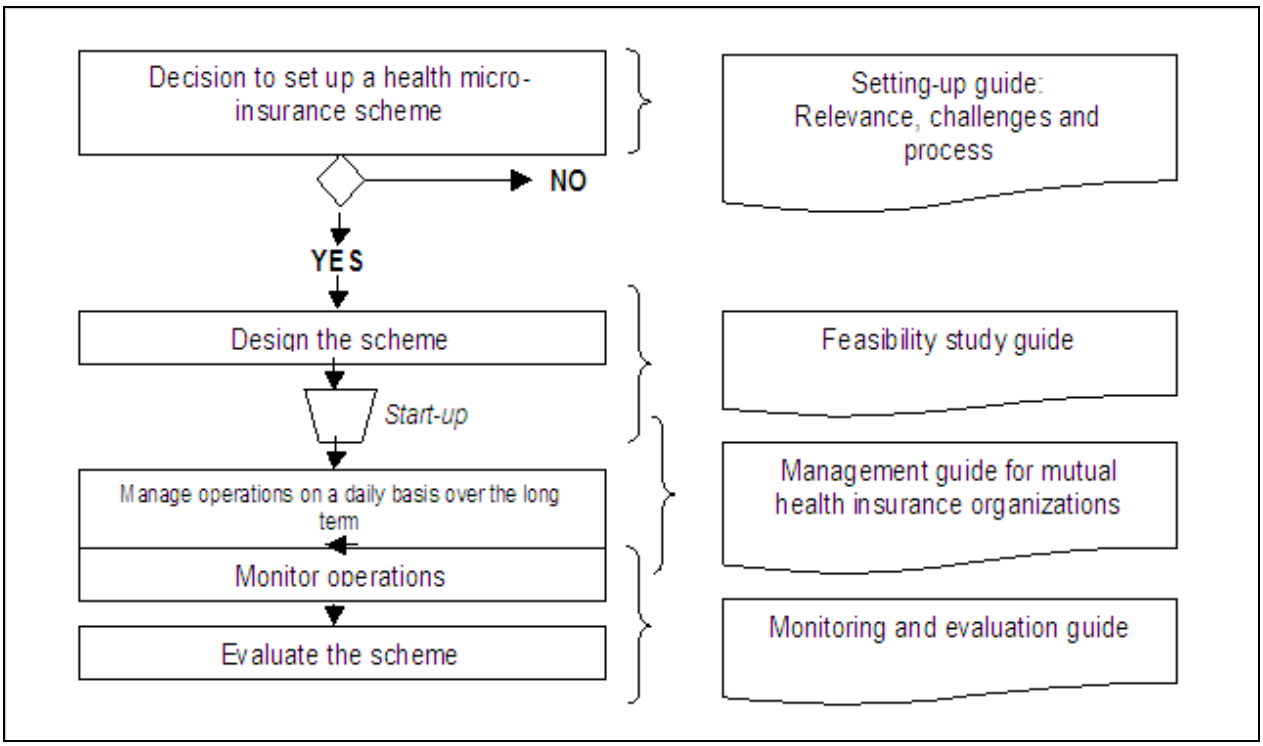
health and health financing issues and a solid understanding of the targeted population socio-economic profile. Setting-up a health micro-insurance scheme is always a unique challenge that needs to fit into a given context as demonstrated by the existing diversity of HMIS in terms of organisational structure and/or benefit package provided. Eventually, deciding to set –up a viable and sustainable health micro-insurance scheme does usually involve a significant and rather long-term investment.

Based on those observations, the rationale of the present introductory guide is to provide potential promoters with elements that might be essential to understand and to account for before deciding to engage in the setting-up of a health micro-insurance scheme.

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

What are the objective and scope of the Guide?

Setting up a Health Micro Insurance Scheme: relevancy, challenges and process introduces a structured series of guides produced by STEP; the other guides therefore pick up where this one leaves off. *The Health Micro-Insurance Schemes: Feasibility Study Guide* enables actors to design a health micro-insurance scheme and, consequently, to determine its organization and operating rules. It does not, however, provide a detailed explanation of the day-to-day management of the scheme, which is the subject of the *Guide de gestion des mutuelles de santé en Afrique (*ILO-STEP, 2003) (Management guide for mutual health organizations in Africa). For their part, the tasks of monitoring and evaluation are examined in details in the *Health micro-insurance schemes: monitoring and evaluation guide (Guide de suivi et d'évalation des systèmes de micro-assurance santé* - ILO/STEP and CIDR, Centre International de Développement et de Recherche, 2001) . The following diagram illustrates the delineation of the respective scope of each Guide:



This present guide neither offers a "magic formula" for setting-up a HMIS nor provides a precise and systematic explanation of how health micro-insurance scheme functions. As an introductory guide, the main objective of this document is to provide potential promoters with a minimum set of knowledge that might be useful to guide them in their decision to set-up a health micro insurance scheme. However it is not a pre-feasibility study guide either and *The Health Micro-Insurance Schemes: Feasibility Study Guide* should be consulted for methodological guidance regarding that matter[2].

[2] Valérie, puis je vraiment indiquer cela, il n'y pas vraiment d'éléments méthodologiques pour mener la pré faisabilité en fait, non?

The present guide is structured into three Parts that deal respectively with HMIS setting-up 's *Rationale and relevancy*, *Challenges* and *Process* as detailed below:

Part 1 _ Setting up HMIS, rationale and relevancy

That gives elements to:

- understand the need to protect "excluded groups" against catastrophic health expenditures and inappropriate access to health care related to financial reasons and therefore understand the rationale for setting up a HMIS;
- understand the core characteristics of a HMIS and approach a definition of HMIS;
- evaluate when using health insurance mechanism to protect "excluded groups" is relevant and to understand which pre-conditions should be met to set-up a HMIS;
- clarify HMIS' potential and limitations in regards to "excluded groups"' protection against catastrophic health expenditures and inappropriate access to health care due to financial reasons.

Part 2 _ Setting up a HMIS, challenges

That gives elements to understand:

- the general functioning of a HMIS; the general and specific challenges when aiming to set-up a viable scheme;
- technical options that promoters will have to consider when designing membership rules, benefit package –premium formula, conditions to access health services covered by the scheme and tradeoffs that will have to be found to build a viable and sustainable scheme;
- key questions that HMIS will have to answer when designing the scheme organisational structure;
- key capacities and tools that should be put in place when aiming to set up a sustainable HMIS;
- the current diversity of HMIS organisational set up and benefit package given the fact that, beyond some technical standard requirements, there is no unique perfect model to follow when setting up a HMIS.

Part 3 _ Setting up a HMIS, process

That gives elements to:

- understand which logical phases that may be followed when setting-up a HMIS;
- review each logical phase's possible content;
- acknowledge some general lessons gained from HMIS experiences so far regarding the setting-up of viable and sustainable HMIS.

To whom is the guide addressed?

The Guide is primarily conceived for community-based organisations, microfinance institutions, cooperatives, trade unions, local or international NGOs, as well as health care providers, that are questioning the possibility to set-up a HMIS and are looking for some introductory knowledge to check the relevancy of such a decision and get a broad understanding of the associated requirements in terms of design, management and setting-up process.

The Guide is aimed at potential promoters regardless of their geographical location: Africa, Southeast Asia, the Indian subcontinent, Latin America.

More generally, the Guide is aimed at new comers (researchers, students, donors, etc.) in the field of Health Micro Insurance who wish to gain an overview of HMIS setting-up rationale, challenges and process.

Part I Setting-up a Health Micro Insurance Scheme, rationale and relevancy

I.1 Setting-up a Health Micro Insurance Scheme, rationale

I.1.1 Illness financial impact and the need for protection against health financial risks

In most Low and Middle Income Countries (LMIC), the levels of economic development, social institutions and labour markets make it difficult to provide adequate social protection (contribution-based social insurance schemes or tax-financed health and social benefits) to all citizens.

With narrow tax-bases, governments often fail to ensure the provision of free or highly subsidised health services to the population. Public health facilities turn to be inappropriately staffed, particularly in rural and remote areas, and experience regular shortages of drugs and equipment breakdowns. Eventually individuals have to pay for formal, informal fees or under-the -table payments for medical consultations and drugs whether at basic health facilities or public hospitals.

Given the generally poor quality of care delivered in public facilities, even some poor patients may turn to seek care from private health providers as they may accept deferred or in kind payment. Private health providers, most of them unregulated, have no incentive to discourage irrational use of drugs and patients may eventually receive inappropriate and expensive care (WHO, 2005b; Preker et al, 2004).

For the majority of LMIC that have developed social health insurance, extending health insurance to informal workers is still behind targets. Except for notable exceptions, such as the Republic of South Korea that reached universal coverage, only the limited fraction of employed workers is usually covered, leaving the majority of the population without any efficient protection against ill health financial impact (Reynaud 2002; WHO, 2005b).

Overall, health expenditures are largely borne by households who mostly depend on informal mechanisms to manage health financial shocks and therefore enjoy very limited protection. In that context, illness costs can generate exclusions from health services and/or catastrophic expenditures that can trigger illness poverty vicious circle.

I.1.1.1 Illness financial burden and household's informal coping strategies

Illness financial burden

Illness is an unforeseeable event; it is impossible to know in advance if it will and when it will happen, how long it will last, how much it will cost, nor weather it will be a serious or a minor case.

At the time of illness individuals who seek care have to face at the same time a rise in expenditure to access health care and a drop in income.

(1) Illness implies a rise in expenditure

Seeking care at the time of illness may entail:

- Direct medical costs for prevention, care and cure such as user fees for pre-natal consultations, for general consultations, fees for laboratory exams, drugs fees;

- Direct non-medical costs such as: costs for transportation, food, small equipment in case of hospital stay for the caretaker, etc;

- "Hidden" costs such as under-the-table payment (in addition to official fees) and unofficial fees (in care free context) for instance in contexts where health officers want or need to supplement their salary.

(2) Illness reduces income-generating capacity of a household

In addition to medical and non-medical direct costs when using health services, illness implies indirect costs (opportunity costs) as it causes a loss of productive time for both patients and caretakers.

When a worker is afflicted by illness, his/her productivity is reduced, leading to a drop in earnings that in turn makes it even more difficult to pay for care; the caretaker (e.g. spouse or parents) may have to stop working for a few days, leading again to a drop in earnings. When the major income earner in a family falls ill and dies, besides the emotional burden, the household's earning capacity is drastically reduced. In consequence the household may be forced to modify or decrease its expenditure and investment patterns that can in turn affect its ability to cope with further shocks.

In financial terms, illness can represent a:

(1) Minor risk: minor risks refer to slight diseases that require less expensive care but which occur rather frequently such as primary health care consultation.

(2) Major risk: major risks refer to severe illness conditions that require hospital and or expensive treatment such as for example surgery or hospital based specialised services. These serious illnesses have a low probability of occurrence but the cost they entail is usually beyond one family financial capacity.

Focus
Illness financial burden

Studies on illness financial burden reported by Russel (Russel 2003) in Burkina Faso, Nigeria and Sri Lanka show that indirect/opportunity costs associated with the loss of productive time was the major component of the total cost of an illness episode with a share higher than 70% of the total costs. Similarly, studies reported by Gouge and Govender (Gouge and Govender, 2000), showed that in Nepal for afflicted households, the income lost represented 70% of the total costs incurred during the disease; in Ghana, it was estimated that the time spent to seek care and take care of the sick person represented 79% of the total financial burden generated by the illness.

Regarding medical and non-medical direct costs, their absolute and relative burden vary according to the severity of the disease, the health system and access to services in the different settings, whether user fees are charged at government facilities, the extent of the insurance coverage and distance to travel (Russel, 2003). In some countries, some health services might be provided free of charge (such as hospital care in public hospitals in Sri Lanka, maternity services in public facilities in some selected poor regions in Senegal) but households seeking care will still have to face transportation costs and other non-medical costs of accessing care. Low level of spending on direct costs may also be associated with problem of access and partial financial exclusion when households do not have the capacity to pay the full treatment for example.

Sources: Russel (2003); Gouge and Govender, (2000)

Household's informal coping strategies

At the time of illness, individuals excluded from existing formal protection mechanisms, may develop and combine several strategies (see table n°) to cope with both financial and time costs associated with the illness of a family member.

They may use their savings, borrow money from relatives and/or adapt their labour force and earning sources. Households can also call on solidarity networks such as mutual self-help groups that can be observed within extended families, ethnic groups, neighbourhood groups and professional networks. Mutual self-help groups generally operate through transfers, gifts, or loans between members, typically with expectations of reciprocity. In more extreme cases, afflicted households may be forced to drastically reduce their consumption and/or sell assets.

Overall, strategies adopted by households essentially vary according to the severity and intensity of the illness shock and households' available assets such as physical, financial assets and its social network. Strategy may also vary depending in who is sick within the family. For instance, compared to a disease afflicting a child, the illness of a major breadwinner will limit options to

cope with the cost of seeking care, as the earning capacity will be directly and more significantly decreased.

Table n°_Households possible coping strategies to face illness direct and indirect costs

– **Depleting savings**	Use available cash in hand Use savings in cash Sell livestock
– **Borrowing money**	Borrow money from relatives or friends Call on debts from money lender Divert credit from it original purpose
– **Calling for solidarity**	Local mutual organisations such as mutual self-help groups, village associations, religious committees, etc. for financial contribution or labour exchange
– **Adapting labour force and earning sources**	Diversify income sources Increase working hours Use intra-households labour substitution Migrate to find extra job Hire labour
– **Reducing consumption**	Cut back on purchase of non essential goods Reduce food consumption Defer investments (e.g. withdraw children from school)
– **Adapting health seeking behaviour**	Delay consultation or admission Discharge the ill person from hospital earlier than required Shift demand to other providers (nearer, cheaper, allowing payment delays) Purchase incomplete treatment Defer or default payment
– **Selling assets**	Sell or mortgage house, land, productive equipment

Sources: adapted from
Waelkens et al. 2005, ILO ESS paper n°22
Cohen et al. 2003, Micro Save Africa.
Goudge and Govender 2000, Equinet policy series n°3

Households may also adapt their health seeking care behaviour to try to reduce the direct costs of using health services. Households may:

- Delay consultation or admission;
- Discharge the ill person from hospital earlier than required;
- Shift demand to other providers (nearer, cheaper, allowing payment delays);
- Purchase incomplete treatment;
- Defer or default payment;
- Do not seek treatment at all.

Depending on the sources and levels of income of households and the nature and level of the financial barriers (illness' direct and indirect costs) partial, seasonal or temporary exclusions may be observed.

Economic exclusion affects very poor families and occurs when non-existent or insufficient income throughout the year implies a permanent impossibility to afford health care expenses and related costs.

Financial exclusion affects families that may face temporary, partial or seasonal difficulties in financing health care:

a) Temporary (financial) exclusion occurs when the family does not immediately have the necessary means to pay illness-related expenses, with consequent delays in seeking care while the wherewithal is found.

(b) Partial (financial) exclusion relates to users of health services who do not have enough resources to pay for all requisite care and/or prescribed treatments.

(c) Seasonal (financial) exclusion affects families whose incomes fluctuate over the year. For example, the incomes of rural households are often concentrated during one or several periods, generally corresponding to the time when they sell their crops. These households may encounter major difficulties during the rest of the year in paying health expenses, even for minor ailments.

I.1.1.2 Shortcomings of informal individual coping strategies and exclusion from health care services

As they essentially depend on households' capacity to mobilise assets and social network, informal individual coping mechanisms offer limited protection. They may prove insufficient for poorest households and when individuals face large medical expenditure related to hospitalisation for acute condition or expensive treatments for chronic illnesses.

Precautionary savings that households build-up, stocks such as livestock, food, jewellery can be depleted in hard times but may be of insufficient amount to cope with catastrophic health spending. Selling off assets may take some time whereas "illness does not wait". During widespread shocks (epidemics), assets prices tend to fall as many sellers may flood the market with distress sales.

Similarly, mutual support arrangements may provide adequate support in case of small illnesses of short duration and low intensity, but may be less effective when illness involves major expenses or affects a large number of households at the same time (e.g., epidemics).

As for poor and very poor households, little coping mechanisms are available or accessible to them in case of financial health shocks. They often survive on a daily wage that is barely enough to meet minimum food requirements and does not allow building significant precautionary savings or accumulating other assets. They usually cannot access credit as they have little guarantee to offer. Besides, solidarity networks are based on selective membership and guided by a principle of balanced reciprocity. They might function well for the "insiders", but vulnerable households (e.g., in-migrants to communities, very poor households, ethnic minorities, elderly and disabled, chronic ill persons) may be excluded from membership, particularly since no counter-gift can be expected from them.

In addition, coping strategies are specific short-term responses to illness events that may have medium and long-term repercussions. Delaying seeking care, receiving inappropriate/ incomplete treatment or totally foregoing care can have dramatic consequences as it entails the risk of worsening health condition that may later requires emergency expensive treatment. Some coping strategies may ultimately compound the family's poverty or vulnerability when they imply a heavy indebtedness or the loss of a production tool. For example in India, a World Bank study[3], reported that hospitalised Indians spent 58% of their total expenditures on health care and that more than 40 percent of those hospitalised borrowed money or sell assets to cover health care expenses. In some extreme cases, the impact of coping mechanisms may contribute to a sequence of events leading to destitution (Bloom, 2005). In turn, poverty may further limit access to appropriate care and households' ability to prevent and mitigate the impact of health related shocks triggering the illness poverty vicious circle.

Focus
Illness financial burden and catastrophic health expenditure, some figures

Studies on illness financial burden reported by Russel (Russel 2003) in Burkina Faso, Nigeria and Sri Lanka show that, in average, the total cost of illness (direct and indirect costs and all illness considered) represents around 12% of households' income. Russel (Russel, 2003) also reports a fraction from 2.5 to 7% of households' income for direct medical and non medical costs with some studies estimating direct costs above 10% of households' income. This fraction can reach 15 to 20% for poor households. Poor households usually spend less on medical care as they have limited access, lower capacity to pay or seek care in public health services that are cheaper. However, health spending may often represents for them a catastrophic expense as they have lower levels of income (Russel, 2003).

Health spending can be viewed as catastrophic "when a household must reduce its basic expenses over a certain period of time in order to cope with the medical bills of one or more of its members" (Kawabata et al. 2002). Some thresholds have been proposed to further qualified health expenditures as catastrophic but no real consensus emerged so far. Some studies consider that 10% of the households income represent a catastrophic payment (in Russel, 2003; Ransom, 2002) and the World Health Organization (WHO) set a higher threshold as it consider health spending as catastrophic whenever it is greater than or equal to 40% of the individuals/households' capacity to pay. "A households capacity to pay is defined as effective income remaining after basic subsistence needs have been met".

[3] Peters D, Yazbeck, et al. (2001). Raising the sights: better health systems for India's poor. Delhi. Washington DC: the World Bank Health, Nutrition, Population Sector Unit: 173.

A multi-country analysis (Xu et al., 2003) has shown that higher rates of catastrophic health payments were associated with higher share of out-of-pocket payment in the financing of health expenditures and confirmed the need for low-income countries to develop risk-pooling mechanisms to protect households against ill health financial risks.

Sources : Xu et al. 2003 The Lancet Vol 362. ; Kawabata et al. WHO bulletin, 2002; Ransom (2002)

Given the limitations of formal public protection device and the shortcomings of individual and/or collective traditional coping mechanisms, civil society organisations operating at community level such as local communities, not for profit health providers, microfinance institutions, local or international non-governmental organisations, trade unions, have developed health insurance services tailored for low-income households under Health Micro Insurance Schemes. In the general context of poverty reduction strategy in LMIC, Health Micro Insurance Schemes have gained a growing interest and support these last years and some initiatives are now being developed as governmental initiative or under its supervision (for example in Laos and in Rwanda).

Extending social insurance coverage and/or increasing public health spending to limit households out-of-pocket payment and improve provision of health care to reach excluded groups, are generally not in the immediate reach of LMIC and experiences show that several strategies will have to be combined to move progressively towards universal coverage (WHO, 2005). As proposed by ILO in its report[4] to the 89th session of the International Labour Conference in 2001, developing HMIS may be part of the strategies to be explored and combined in the search for social protection for all.

I.1.2 Health micro insurance scheme to contribute to protect excluded groups against ill health financial impact

Health Micro Insurance Schemes

Health Micro-Insurance Schemes (HMIS) can be defined as health insurance schemes tailored for individuals and households who do not enjoy any form of social protection in health (excluded populations) and who face financial barriers in accessing health care.

Financial barriers, such as large medical care costs or transportation costs at the time of illness, may limit access or discourage the use of appropriate health care and entail the risk of impoverishment when individuals face severe illness.

[4] ILO (2001), Social security, a new consensus, 114 pages.

In the overall search for reducing and preventing poverty, setting-up a Health Micro-Insurance Schemes (HMIS) at community level generally try to answer the needs to:

(1) Protect excluded populations from catastrophic expenditures associated with serious ill health events or conditions;

(2) Improve excluded populations' access to health services when financial barriers exist.

Excluded populations

Excluded populations are households or individuals excluded from social protection[5] in health. They include people active in the informal economy in urban settings and most of the households in rural areas. They can also be employees in small workplaces, self-employed and migrant workers. They generally show a greater likelihood of being exposed to serious occupational safety and health hazards.

People excluded from formal social protection usually display low, seasonal and irregular income and have limited assets:

- Human assets such as education and health status;
- Physical assets such as land, house, livestock;
- Financial assets such as credit, savings and insurance products;
- Social assets through family or solidarity networks.

Exclusion from social protection has also significant gender dimensions since in many countries a higher proportion of women work in the informal economy (ILO, 2001). Women can more easily combine informal activities with their family responsibilities and may also encounter discrimination to enter the formal economy (ILO, 2001). Besides, recent social and demographic changes (divorce, female-headed households, etc.) have left more and more women with heavier burdens and fewer means to care for themselves and their families.

Although excluded are to be found in low-income groups, the term "excluded" cannot be understood as "the poorest" only. In line with Waelkens et al. (Waelkens et al, 2002), who propose to consider transient and chronic poverty situations, two broad categories might be distinguished:

- Excluded individual/households who are concerned with limited resources to protect themselves against unexpected rise in expenditures and/or loss of income and therefore are very vulnerable to financial stress but have a minimum capacity to financially contribute to a scheme on a regular basis.

[5] Social protection is defined to include not only public social security schemes but also private and non-statutory schemes with a similar objective.

– Excluded who are concerned with deeper level of poverty that impedes them to financially contribute to a scheme on a regular basis.

HMIS can be regarded as an option for excluded groups who cannot afford health expenditure on an individual basis but who may be able to face it when collectively shared and arranged. As joining Health Micro Insurance Schemes requires a regular financial contribution, as modest as it may be, they cannot be a relevant option alone to protect households concerned with deep poverty (see section 1.2.2 HMIS potential and limitations).

I.2 Setting-up a Health Micro Insurance Scheme (HMIS), relevancy

Improving access to health care services for excluded households and protecting them against illness financial shocks may be tackled at different levels and with different strategies and instruments. Reasons for limited access to health care and vulnerability to health financial shocks are indeed contextual, multiple and call inevitably for a combination of responses (policies). If the objective is to remove or reduce barriers to health care, it will be critical to identify and understand the very nature of the exclusion experienced by the target population in accessing care.

As the World Health Organisation distinguished it in its annual report 2005[6], reasons for exclusions can be approached as external and internal of a given health system.

Regarding *internal reasons*, exclusion may be associated with the way provision and financing functions of the health system are designed and regulated (or unregulated). For people who do use the services, health services offered may be expensive, "untimely, ineffective, unresponsive or discriminatory" (WHO, 2005a).

As for *external reasons*, exclusion may stem from the demand-side in relation with poverty, race, language and culture as well as barriers generated by geographical isolation.

Exclusions linked to inadequate provision of health care will not call for the same strategies as exclusions associated with inappropriate demand for health services. Similarly protecting people who are in deep poverty will not ask for the same strategies as protecting people who are poor but are able to display a minimum capacity to pay. Some strategies may require government stewardship and financial support; other may be initiated at community level with or without external support and some may involve public-private linkages such as Health Micro Insurance Schemes.

When limited access to health care is mainly linked with geographical difficulties, cultural or interpersonal inhibitors, a problem of overload of the health care facilities, or on the opposite a

[6] WHO (2005a) The World Health Report 2005, Make every mother and child count.

problem of poor quality of the health care services, the set-up of a community based health insurance scheme may not be a sufficient answer, and may not be relevant, until these underlying problems remain unsolved.

If exclusions are identified to be linked with financial barriers in accessing health care, health insurance will be part of the financial instruments that can be used to address demand side's limitations and setting-up a Health Micro Insurance Scheme will be part of the strategies that may be initiated at community level under certain conditions. If exclusions are not linked to financial barriers, other strategies might be considered.

Overall, setting-up a Health Micro Insurance Scheme may allow:

- Dealing with existing financial barriers when seeking health care at the time of illness;
- Using the potential of insurance mechanism to overcome saving and credit instruments shortcomings to limit ill health financial impact and reduce financial barriers to health care for people outside formal social protection;

With some limitations, as it may:

- Not be a relevant answer in all contexts, as it requires some preconditions;
- Call for a comprehensive strategy to enhance its potential protective effect against ill health financial impact and offset its own limitations.

I.2.1 Health Micro Insurance Schemes (HMIS), preconditions

I.2.1.1 General characteristics and technical relevancy

The term Health Micro Insurance Scheme encompasses a wide variety of schemes. Existing Health Micro-Insurance Schemes differ one to another in regard to the benefit package (health services covered), the membership formulas, the organisational structure, the degree of involvement of the target population in the decision making process, as well as the degree of financial solidarity between members for example (see part II).

However, beyond this diversity, Health Micro-Insurance Schemes, considered in the present guide, display a minimum set of common features as they:

(1) Involve the insurance mechanism with micro-transaction as they deal with small size premium and expenditures and operate at rather decentralised level for the premiums' collection and claims' management.

(2) Are designed for "excluded populations" who are not enjoying any public or private protection arrangements. In that regard, HMIS as referred in this guide do not include supplementary insurance schemes for population already partly covered by formal social insurance scheme.

(3) Are initiated by organisations from the civil society such as community-based organisations, international or local NGOs, Micro-Finance Institutions, trade unions, commercial insurers (as in India) and health providers. They are schemes that involve, to a more or less extent, the target population, in the design of the benefit package or/and in the management of the scheme. The inclusion of health micro insurance schemes originally stemming from a public initiative to reach "uncovered" persons through voluntary not-for-profit private schemes may be considered when those schemes are managed independently from the State and include beneficiaries at some point in the design process and/or within the decision-making bodies. Community based health insurance schemes piloted in Laos and Rwanda for example may come under this category[7].

(4) Are voluntary schemes in which the target population freely decides to register or not to the scheme. As it will be discussed further, this characteristic is a core characteristic of HMIS that has significant implications in terms of design, management and coverage of such schemes. It is a major distinction with social health insurance schemes that are compulsory by nature.

(5) Have a non-commercial approach but a social mission that notably translates into the calculation of the premium on a collective basis and not on an individual basis with individual risk related premium.

Health Micro-Insurance Schemes share a core characteristic as they all operate on the basis of the insurance mechanism to mitigate health financial risks. Consequently, they all entail:

- *Resource- pooling*: all insured members make a prospective non-refundable contribution for a given period, the premiums, that are pooled together to form the insurance fund.

- *Risk- sharing:* insured members share a pre-selected set of health risks and the pooled premiums are used to provide a predefined benefit to insured persons who face health risks listed. Insured persons who are not exposed to risks over the period cannot claim back for their premium. This implies a transfer of subsidies from individuals with lower risks to those with higher risks.

- *Guarantee of coverage:* against their premium the insured persons gain the certainty of receiving a given pre-defined benefit (the payment or reimbursement of health expenditures encountered or a predefined financial compensation - cash benefit) when they meet pre-defined risks.

[7] WHO (2004) Social health insurance, selected case studies from Asia and the Pacific,

In principle, insurance financial instrument is relevant to protect against risks that:

- Are not very likely to occur and are not predictable such as injury following a car accident; delivery are de facto predictable but complication during delivery are not predictable such as the need for a caesarean section; in comparison the need for primary health care services have a higher probability to occur;
- Involve a significant and measurable loss such as an hospitalisation with surgery charged following an official user fees schedule;
- Are not controllable by the insured person such as appendectomy that cannot be self-inflected in opposition to self inflicted in suicide attempt;
- Are not dependent from one person to another such as the need for a caesarean section in opposition to a cholera epidemic.

In line with those principles, health insurance will be technically appropriate to protect against health risks that are not very likely to occur but may involve costly treatment such as hospital care. These risks can be distributed over a large number of individuals and the insurance contribution or premium will be low for each insured household in comparison to the expenses that would have been faced without insurance in case of illness.

As illustrated in a very simplistic and simplified example in the table n°_, insurance transforms a low probability of facing a large expenditure into a small but certain loss (the premium). In the example given, the insured person has to pay 3 000 MU to be certain to avoid the risk (during one year) to pay 150 000 MU in case of hospitalisation with a surgery. Besides, with resource and risk pooling mechanisms, insurance provides a more efficient protection against low-probability and high-cost health risks than individual savings and emergency loans.

Table

	Total health care costs in MU (a)	**Frequency (%)** (b)	**Payment in case of illness event MU (insurance will be paid even if the illness does not occur)**		**Monthly capacity to pay required (MU)**
Hospitalisation for surgery					
Hospital stay and drugs	150'000	2%	Insurance premium (a) x (b)	3'000	250
			Free loan repayment (a)	150'000	12'500
			Accumulated savings (a)	150'000	12'500
Primary health care services					
Basic laboratory test					
Consultation and test	1000	30%	Insurance premium (a) x (b)	300	25
			Free loan repayment (a)	1000	83
			Accumulated savings (a)	1000	83
Primary health care services					
General consultation					
Consultation including drugs	1000	100%	Insurance premium (a) x (b)	1000	83
			Free loan repayment (a)	1000	83
			Accumulated savings (a)	1000	83

MU:monetary unit

Focus
Savings, emergency loans and insurance to mitigate health financial risks

Savings, emergency loans and insurance are financial instruments that can be made available for excluded households to help them mitigating health financial risks.

Offering timely and affordable access to emergency loans in case of large health expenditure can help households to smoothly recover from the financial shock without depleting their assets. Emergency loan for unexpected health expenditures may not be the most appropriate instrument for low-income population since reimbursing may be difficult when labour force and earning capacity have been reduced with the illness of one active member of the family. Access to emergency loan at community level through formal micro-finance institutions is overall very limited. A specific case has been reported in Luweero district in Uganda where a HMIS[8] (covering hospital care only) is proposing a mix of emergency loans and insurance products as, in some part of the district, the target population was reluctant to accept the insurance concept for very rare health risks covered by the scheme.

Offering low-income people the possibility to save money for health and /or to prepay for some services may enhance access to health care as it allows a person to pay or save money for future care at a time when she/he has the resources to do so. Savings (financial deposits) create a buffer against health expenditure and can be mobilized more quickly than real assets. Except in case of high inflation, savings are also less likely to be depreciated when covariate shocks occur (e.g. epidemics). Prepaid services can facilitate access to specific services such as mother and child care, pre-natal consultations, ultra sound scan (see case study box n°).

However, savings and prepaid services are individualized mechanisms whereby households can only use the amount of services they have pre-paid or draw upon the amount of money they have saved. Households who have higher income and are able to accumulate more in their savings accounts will be able to afford the care they need. Those with limited income or patients with chronic conditions will be unlikely to have accumulated enough resources to pay for their health care expenses. As for individual informal coping mechanisms, even if well designed and easily accessible, individual savings and prepaid services alone will provide limited protection for poor households and in case of large medical expenditure.

For minor risks, such as general consultation at primary health care facilities that have high probability and generally rather low costs (during a year individual may have at least one contact with a health provider for minor ailment), health insurance may not be much more efficient than individual savings or prepaid services in reducing financial barriers to access appropriate health services. When a health risk has the probability to occur to most insured persons during a given period then the cost of the insurance would be very close to the actual expense of the health care without insurance. When the use of health services is predictable as pre-natal consultations and delivery care for pregnant women, offering the possibility to prepay specific range and quantities of services may also be an appropriate response to remove financial barriers and enhance access to health services. People who prepay health services (such as consultation tickets) show the tendency to use all prepaid care even if the persons did not really needed them. Given this

[8] USAID, PHRplus 2005, The Good Practice Model: community participation in Luwero District, Uganda. The HMIS is supported by a local association Save for health Uganda and by CIDR (Centre International de Développement et de Recherche, http://www.groupecidr.org)

tendency, prepaid services may be particularly relevant when they concern preventive care that are usually not a priority for households in scarce resource settings.

According to insurance general principles, setting-up a HMIS will be technically relevant to cover hospital services when financial barriers, such as user fees at the point of use, deter access to health care or push households into indebtedness when they need hospital care. In practice, as it will be explained later in the present guide (see part II, HMIS diversity), HMIS will often incorporate a proportion of prepaid services into their benefits package as they will generally have to cover both hospital and primary health care to enhance their protective effect and better answer excluded households' health needs.

Case study box
The obstetrical package in Nouakchott, Mauritania

Since November 2002 in the capital city in Mauritania, a range of public maternities offers an obstetrical prepaid package ("*forfait obstétrical*") to pregnant women including: four prenatal consultations, a blood test, an ultrasound scan, care for normal or complicated delivery with caesarean section and ambulance facility when the pregnant woman is evacuated to the referral maternity.

This specific scheme, supported by the national Ministry of Health and the French Cooperation, integrates a part of prepaid services (prenatal consultations, ultrasound scan, delivery care, postnatal consultation) and a part of insurance for low probability high cost health risk such as delivery with caesarean section.

The mix of preventive prepaid services and insurance services for complicated delivery allows reducing the risk of complication during delivery with an appropriate follow-up of the pregnancy and offers a significant protection in case of complicated delivery for an overall affordable lump sum premium. The package costs 6000 local monetary unit to avoid health expenditures ranging from 14 200 to 42 000 local MU. The scheme is subsidised in its pilot phase until it reaches a sufficient scale to be self-sufficient.

In 2004, 92% of the pregnant women using the public maternity proposing the obstetrical package chose to buy it.

Source: *Équilibres et populations N°92- October November December 2004, p 15*.

I.2.1.2 Preconditions

Even if technically relevant to deal with financial barriers, setting-up a HMIS is unfortunately neither a panacea nor a systematic appropriate answer to excluded populations' needs in terms of access to health care and protection against catastrophic health expenditures. Some preconditions will have to be met to ensure that setting-up a HMIS is a relevant and feasible option.

So far, six conditions might be regarded as preconditions for the setting-up of a relevant Health Micro Insurance Scheme. Three preconditions are related to the target population potential demand for insurance services; two are linked to health care provision and financing and one is concerned with legal issue. Some of the preconditions might be interlinked.

Checklist
Preconditions to set-up a HMIS

- ❑ Precondition 1:Is there an actual need for coverage against ill-health financial consequences?
- ❑ Precondition 2: Are health services of acceptable quality available?

IF NOT, setting-up a HMIS will be neither relevant nor feasible as a first step

- ❑ Precondition 3: Is there a stable health financing policy?
- ❑ Precondition 4: Is there any prohibitive legal constraint?

IF NOT, setting-up a HMIS will not be feasible

- ❑ Precondition 5: Does the target population trust the project initiators and other actors involved?

IF NOT, setting-up a HMIS will be difficult as a first step

- ❑ Precondition 6: Is the target population potentially large enough from the start?

IF NOT, HMIS will be difficult to sustain

Precondition 1: there is a priority need for coverage against ill health financial consequences

The future HMIS will provide a solution to the financial difficulties experienced in paying for health care. Financial difficulties must not only exist but also be considered by the target population as a priority or at least a major concern.

In very poor contexts (such a post-conflict areas or areas suffering or recovering from massive drought or flood), where people struggle to survive and where daily feeding is a problem; health issues tend not to be considered as a priority. It will be very difficult to set-up a HMIS in such contexts that actually will require social assistance to ensure appropriate access to health care.

In contexts where health care services are free of charge, the financial difficulties may seem to be inexistent at first glance; but other financial difficulties related to health care (for instance non

medical costs such as transportation costs, patient caretakers expenses during hospital stay and opportunity costs) may justify the set-up of a HMIS providing cash benefit in case of hospital stay with emergency evacuation for example.

In contexts where households can access a comprehensive range of free health care delivered by confessional health providers, they will be less likely to be interested in joining a HMIS that proposes to pay for insurance to ease the access to public health services with similar level of quality in the area.

Precondition 2: health services of acceptable quality are available

The future HMIS will provide benefits to those members (and dependants) that are using the services of one or several health care providers (health posts, health centres, hospitals, etc.). Obviously proposing households to pay a certain amount of money in advance to receive health care from a health provider that is not open 24hours and face regular shortages of staff and drugs, will not be a workable strategy.

Setting-up a HMIS will be feasible if:

- The target population has at hand a range of health care services that meet its major health care needs;
- The target population is willing to use these services; that is, the selected health providers are well perceived by the target population.

The availability of acceptable quality of care is a cornerstone in the development of a relevant and viable HMIS. Existing health care services should address target population's major health care needs, be located not too far away from the target population, be of relative good quality and well perceived by the target population. When health care providers don't meet these criteria (for instance, they regularly run out of drugs or pay little attention to patients), setting-up a HMIS will not be the relevant first step to address excluded households financial difficulties in accessing appropriate care. In such contexts, three options might be considered:

(1) Renounce to set-up a HMIS or postpone the project until quality of care is improved;
(2) Plan - within the project of setting up a HMIS - to increase quality and availability of health care services before the setting-up of the HMIS. Agreements between health micro-insurance schemes and health care providers can contribute to increase the quality of health care or the number of health services provided;
(3) Plan - within the project of setting up a HMIS – to create supplementary health facilities such as SEWA in India[9], ORT Plus[10] in Philippines that have implemented and organised the management of primary health care facilities. This last option involves the design and

[9] ILO STEP Case study

[10] ILO STEP Case study

management of a specific project that requires specific skills and appropriate financial strategy.

If there is no priority need for insurance coverage against illness financial consequences (precondition 1) and if there are no health services of acceptable quality of care available (precondition 2), setting-up a HMIS will not be relevant or feasible as a first step and other strategies should be considered first.

Case study box
Improving quality of care before setting-up a HMIS
The example of SKY Health insurance scheme in Cambodia[11]

Supported by donors' funding and GRET Ngo technical assistance, SKY HMIS in Cambodia has developed specific partnership strategy and contractual arrangement with a public primary health care centre that was not initially matching the necessary quality requirement to set up a relevant HMIS.

This strategy has included:

(1) Before starting health insurance activities: (a) the preliminary support of a medical doctor (SKY HMIS medical advisor) to reinforce health staff skills and (b) a round of meetings to agree on quality of care criteria (that fit existing public and on the capitation payment mechanism from SKY HMIS.

(2) With the start of health insurance activities: (a) the implementation of a temporary bonus system per insured covered, given to the health centre team when pre-selected quality indicators were satisfied (indicators such as, respect of the user fees schedule for uncovered services, rational use of injectable drugs, appropriate use of antibiotics treatment, fulfilment of outreach sessions for preventive care, staff duty at night, patient welcoming, appropriate registration of insured contacts, etc); (b) the implementation of a monthly monitoring of quality indicators performed by the HMIS with monthly debriefing with health centre staff and local health authorities; (c) the regular presence of SKY HMIS medical advisor in the health centre.

The bonus system is designed and has been negotiated to be progressively decreased. It will eventually be withdrawn as it is expected that it will be compensated by the rise in revenue associated with the growth of insured registered in the scheme. The presence of SKY HMIS medical advisor is planned to be progressively decreased.

This specific partnership has been established with the strong support of the local provincial health authorities, UNICEF and donors' funding through GRET Ngo support. Further research will be necessary to document the impact of that strategy. So far the quality of care delivered by the health centre has been improved as reported by insured patients high satisfaction.

Precondition 3: there is a stable health financing policy

It will be critical to have a good understanding of the health financing policy and its reform trend to evaluate if there is risk of policy change that might render the HMIS irrelevant.

[11] SKY HMIS GRET (Groupe de Recherche et d'Echanges Technologiques), http//: www.gret.org

Policy changes regarding health financing may dramatically impact on the relevance of a HMIS. For instance, it will not be relevant to plan to set-up a HMIS to address women's difficulties in accessing and paying for obstetrical care if the government is considering removing user fees for health care related to pregnancy and delivery in public facilities. In that regard, a stable or stabilised health financing policy will be a precondition to set-up a HMIS.

Precondition 4: there is no prohibitive legal constraint

HMIS will have to operate under a legal status and framework. It will be therefore critical to check under which legal framework the future HMIS will be authorised to operate and check if legal requirements are not undermining its feasibility.

For example, if HMIS are to be regulated under commercial insurance legal framework and are required to respect the same capital requirements and prudential ratios, it might not be feasible to set-up a HMIS that can only pool limited amount of premium compared to the volume of policies and premiums managed by private insurance companies. If legal requirements are too constraining and the possibility of being exempted from the current legal requirement is not given, setting up a legal HMIS will not be feasible. (See part II legal issues).

If precondition 3 and 4 are not met, setting-up a viable and legal HMIS will not be feasible.

Precondition 5: the target population trusts the project initiators and other actors involved

Trust is essential in the acceptation of the insurance mechanism in voluntary schemes. It will be critical that the target population trusts the promoter and/or manager of the insurance fund as they will them a financial contribution in exchange of the promise to receive a given benefit in case of illness in the future. Setting-up a HMIS will therefore be difficult as a first step if:

- The target population does not fully trust the promoters of the project or any other actor involved (premium collectors for example). Therefore, the past relationships between the population and these persons are an important element in assessing the feasibility of setting-up the HMIS;
- The target population already experienced problems or failures on similar projects based on resources pooling (service cooperatives, savings and credit funds, etc.). Such experiences should be analysed when assessing the feasibility of setting-up the HMI scheme.

If precondition 5 is not met, setting-up a HMIS will be very difficult and will not be feasible as a first step.

Focus
Solidarity bonds, a favourable factor rather than a precondition

In many HMIS based on mutual management in West Africa, solidarity bonds have been considered as a core precondition for the set-up of a HMIS. Insurance principle is actually difficult to accept and it is expected that the mechanism of resources pooling will be easier to understand when community traditions of mutual help already exist within the population. Community bonds may appear in different situations: inhabitants of a village or neighbourhood, employees of an enterprise, members of a social movement, etc.

Some experiences from other settings have shown that community bonds may not be a precondition but rather a favourable factor regarding the implementation of a HMIS.

It seems that the absence of community bonds may not render HMIS irrelevant as far as households in the target population perceive their individual interest in joining the HMIS. When community bonds have been shattered by past civil war or where solidarity principle is not well accepted among the target population, setting-up a HMIS will still be relevant and feasible as far as it is matching households' needs for protection against illness financial consequences. In such context, setting-up a HMIS will call for a solid communication campaign to explain the benefit and the functioning of the scheme. It will also call for an appropriate support from local authorities to entrust the promoting organisations among the target population, as trust in the promoting organisation is indeed an important precondition for the set-up of a HMIS.

Precondition 6: the expected number of persons covered is potentially large enough from the start

Insurance mechanism requires large number of insured to spread the risk and pool resources adequately and be financially viable. It will be difficult to sustain a HMIS if the target population is not large enough from the start of the activities as in the long run.

This precondition applies in priority for HMIS schemes covering "major health risks" that imply important expenses like hospitalisations, deliveries with caesarean section, surgical operations, emergency evacuations, etc. For those schemes, it will be necessary that the expected number of persons covered is large enough from the start. The calculation of the premiums is generally based on the average health care consumption of the target population (rural population around a district hospital for example). According to the probabilities theories, the smaller the population and the less frequent the covered risks, the greater the variations around the average. Therefore when the covered population is too small, the financial equilibrium of the scheme may be in danger as there is a risk for the actual consumption of services to be higher than the average consumption.

Therefore in order to avoid bankrupting the HMIS from the start and be able to sustain its functioning in the long run, it will be important to have a potentially large enough target population when setting-up an HMIS.

This precondition can be removed when the HMIS is financially supported (e.g. subsidised by donors) to accompany its setting-up and progressive expansion to reach an appropriate number of insured persons.

I.2.2 Health Micro-Insurance Schemes (HMIS), potential and limitations

I.2.2.1 HMIS potential

As already explained, if preconditions are met, setting-up a HMIS can be a relevant strategy to contribute to:

- Improve financial accessibility to health care;
- Limit the financial burden of ill health.

Focus
Actual impact of HMIS?

Few studies so far document the actual impact of HMIS to improve access to health and utilisation rate are generally used as a proxy indicator to illustrate HMIS impact when data are available. In Rwanda prepayments schemes[12], the overall use of curative services for adults and children, and preventive health services for children and women, was up to five times higher for insured members than for non insured members who experienced very low contact rate with public facilities. In Cambodia, compare to non-insured population, SKY HMIS insured members seem to make a more appropriate use of the public health centre with more than two contacts per year by contrast with 0.3 contacts per year for the general population.

Similarly, so far evidence is scarce about the actual financial protection offered by HMIS against catastrophic health expenditure[13] but available data already suggest that HMIS do have a potential to prevent catastrophic expenditure. SEWA case study by Ransom[14] in 2002 revealed that insurance halved the number of catastrophic expenditures cases (that is health expenditure amounting more than 10% of their annual households income) for patients who had faced hospitalisation.

Under certain conditions, setting-up a HMIS may also have the potential to contribute to:

- Improve health seeking care behaviour and encourage rational use of health services;
- Voice users (the excluded) and improve community participation in the health sector.

[12] Schneider et al. (2001) Pilot testing prepayment for health services in Rwanda: results and recommendations for policy directions and implementation, PHR technical report n°66.

[13] ILO/STEP/Universitas (2002), Extending social Protection in Health Through Community Based Health Organisations, Evidence and Challenges. Discussion paper, 74 p.

[14] Ranson (2002), Reduction of catastrophic health expenditures by a community based health insurance scheme in Gujarat, India: current experiences and challenges. Bulletin of the World Health Organisation 2002, 80(8) 613-621

Additional potential can be put forward according to the nature of the promoting organisation of the HMIS:

- Improve financing for health providers;
- Secure credit portfolio for microfinance institutions (MFI).

Improve health seeking care behaviour and encourage rational use of health services

When HMIS can cover both primary health care and hospital care and enforce referral from primary health care facilities to hospital facilities, HMIS will have the potential to encourage a cost effective use of health facilities.

Insured will be encouraged to contact primary health care in a timely manner. Early contact to primary health care will in turn reduce the need for referral at hospital level and limit the degree of severity when referred if the disease requires hospital care.

Insured persons will also be more likely to receive appropriate treatment for a given disease, as they will not be exposed to the decision of forgoing the expensive part of a prescribed treatment in case of limited cash in hand when non-insured.

When favouring generic drugs of controlled quality in their benefit package, HMIS will have the potential to encourage more rational (cost effective) demand and provision of drugs that in turn has the potential to contain overall health care costs and remaining out-of-pocket health expenditure for patient.

As already illustrate with the obstetrical package in Mauritania (see box n°), HMIS have the potential to enhance access to preventive services such as prenatal consultations when they are made mandatory to be covered for delivery heath care service; HMIS may have the potential to guarantee access to safe motherhood; with benefit packages designed in line with public health priorities, HMIS can potentially play a role in reducing illness burden for low income population and therefore contribute to reduce poverty.

Improve heath care financing

From health care providers' perspective, HMIS have the potential to increase patient solvency as well as to ensure increased utilisation of health services. As financially protected, insured patients will be less likely to escape from the hospital at night to avoid hospital bill.

SKY insured members represent 10% of the public health centre catchment population and 36% of its total contacts.

As HMIS have the potential to encourage a more rational use of health facilities as explained earlier, insured patients will generally be encouraged to consult health providers as soon as they are sick and will be less costly to treat which can limit health facilities' expenditures.

Under specific contractual arrangements between HMIS and health providers, HMIS may have also the potential to improve health providers' budget planning capacity when they pay them on a prospective basis (see part II for details on providers payment mechanisms).

NB: see page 42 Tabor 2005

Voice users (voicing the excluded) and improve community participation in the health sector

Contributing to a HMIS entitles individuals with the right to access a given benefit package of appropriate quality of care. Insurance entitlement potentially enhances excluded groups' capacity to ask and claim for appropriate quality of care to contracted health providers.

In HMIS that are not directly managed by health providers, HMIS will act as an intermediate party between insured and health providers. As they operate on a voluntary basis and will have to keep insured satisfied with the benefits, HMIS have a strong incentive to voice insured members needs to partners health providers.

As one of HMIS specificity is to involve insured members at least in the design of the benefit packages and later within monitoring meetings or survey to assess their satisfaction, they have the potential to put a positive pressure on providers regarding quality of care and services. Overall, increased community participation through HMIS may have the potential to improve health providers responsiveness to patient needs.

In Uganda, the HMIS supported by CIDR and SHU hold three insured members general assemblies along the year and monthly monitoring meetings. Monthly monitoring meeting gather representatives from insured members, partner health providers (hospital) and support organisation. These regular meeting give the opportunity for insured representatives to report insured members' satisfaction on health services and to establish a direct dialogue (discuss) with health providers on expectations for improvement regarding quality of care.

Secure Microfinance credit portfolio

Micro-finance institutions (MFI) such as Grameen bank in Bangladesh, SEWA in India or AssEF[15]in Benin, originally developed health insurance services to prevent their members from diverting part of their productive micro-credit to pay for health care expenditure in case of costly illness episode.

[15] reference case study to be released

Checklist
HMIS potential

If preconditions are met, setting-up a HMIS may be a relevant component in a strategy to:

- ❑ Improve financial accessibility to health care
- ❑ Limit the financial burden of ill health
- ❑ Improve health seeking care behaviour and encourage rational use of health services
- ❑ Voice users (voicing the excluded) and improve community participation in the health sector
- ❑ Improve health care financing for health providers partners
- ❑ Secure credit portfolio for IMF
- ❑ Contribute to move towards universal social coverage

Overall, and as already underlined, as they target populations that are currently out of reach of the formal social protection mechanisms, HMIS have the potential to contribute to pave the way forward to reach universal coverage.

I.2.2.2 HMIS limitations

HMIS are serving low-income groups that have very low and fluctuating ability to pay and are particularly exposed to health risks. As a consequence, HMIS face two major in-built limitations:

1) With limited level of premium Health Micro-Insurance Schemes will not be able to meet all the priority health insurance needs of the target population and will provide only a limited financial protection in case of illness.

   For instance, HMIS generally do not have the capacity to compensate for income loss associated with illness episode and usually grant a partial compensation (e.g., 60% of the health care costs) for a limited package of health risks (e.g., hospitalisation, drugs, consultation). Without external financial support, HMIS will usually have to concentrate on essential medical services and leave off expensive specialities or advanced hospital care (dental care, ARV treatment, heart surgery, kidney transplant, etc.) that still are in need within excluded groups. For the same reason they may not be able to take into account the specific needs of some categories of members such as individuals with chronic condition, the elderly and the disabled.

2) As they require the payment of a regular premium, even modest, Health Micro-Insurance Schemes will not be able to include the poorest fraction of excluded groups that is unable to contribute.

If the objective is to provide adequate financial protection to excluded groups against illness financial burden, HMIS inherent limitations will call for complementary strategies to enhance its potential.

To better meet the population's health insurance needs, additional health-related financial services may be offered to members of the community based health insurance scheme such as emergency loan and health savings. Emergency loan and health savings may be useful to finance benefits not provided by the community based health insurance scheme (e.g. primary health care), to finance the co-payment in case of partial coverage of the health care expenses or to pre-finance the health expenses in a system where the members pay the total amount of health expenses and are subsequently claiming reimbursement for the part covered by the scheme. Micro saving services may also be useful to help preparing for the payment of the premium and linkages with microfinance institutions might be explored when available in the same area.

However, as far as health credit is concerned, experience shows that debts are then difficult to recover from beneficiaries. Health savings, for its part, is an individualized mechanism where households can only draw upon the amount of money they have saved: it is therefore merely appropriate for health expenses that are deemed certain and of relative low cost such as non-specialist consultations that occur frequently and are relatively inexpensive.

Regarding the inclusion of the poorest groups that do not have the financial means to contribute to the scheme, different strategies may be considered: HMIS may be used to channel specific government (or donors) subsidies to pay for the premiums of the poorest; linkages with social assistance programmes may also allow HMIS including the poorest groups.

Specific arrangements can be designed and set-up to meet the specific needs of some specific population groups essentially the elderly, the disabled and the chronic ill persons. Specific arrangements may include the use of an earmarked solidarity fund to cover expenses related to selected diseases, partnerships may be explored to fully use the potential of existing vertical public health programmes on specific diseases such as malaria, HIV/AIDS, tuberculosis or leprosy programs.

Preventive and precautionary measures as health education, use of condoms, sanitation, hygiene, immunization, preventive consultations and regular check-ups can either prevent the illness from occurring, reduce the occurrence of illness, or lessen its seriousness. Such measures developed or reinforced in synergy with the setting-up of HMIS can thereby contribute to reduce the future expenses of the community based health insurance scheme, increase its financial accessibility and reinforce its coverage.

Focus
Reduce exposure to health risks with prevention and precautionary measures

Improving prevention and precautionary measures for excluded persons is one of the logical ways to reduce illness financial burden, as such measures may limit part of the health risks.

Preventive measures may prevent the illness from occurring, or only lower the probability of the illness occurring or lessen its seriousness. For instance, when households get their children immunized and apply basic hygiene principles, the risk of falling ill is reduced; if they undergo regular check-ups, the chances of diagnosing a disease in an early stage are increased, thereby reducing the seriousness of illness.

Precautionary measures aim at avoiding risky situations or being exposed to a risk. For instance avoiding risky sexual behaviours contributes to reduce the chance of sexually transmitted diseases (STD).

Preventive actions and precautionary measures are often less expensive than other strategies related to the same risks (for instance, immunization and regular check ups are less expensive than curative health care) and are either more effective (immunization can prevent some diseases). They increase effectiveness of other strategies (early diagnosis of a disease thanks to regular check up increases patient's chances of recovery) or contribute to reduce their cost (the less serious a illness, the lower the cost of necessary treatment).

Though they have the potential to significantly reduce the financial burden of illness for households, the actual costs for prevention are generally perceived by the households as a costly "luxury" related to uncertain future illness, and therefore are not felt as a priority when allocating their scarce resources in the present. Besides, educational and cultural barriers may prevent households from undertaking prevention and precautionary measures.

Linking the setting-up of a HMIS with health education and promotion activities to increase awareness about prevention and precaution may significantly contribute to reduce exposure to illness, then limit illness financial burden and eventually may increase HMIS potential protective effect.

Overall, HMIS inherent potential performances are highly dependent on the nature of their technical design, management, organizational and institutional characteristics (see HMIS challenges in section 2). In that regard, the setting-up process is a critical step to ensure that solid bases are in place for a relevant HMIS (see section 3). In addition to internal factors, a conducive environment may play an important part to enhance HMIS potential in protecting excluded households from illness financial risks.

Part II Setting-up a Health Micro Insurance Scheme, challenges

II.1 Setting-up a HMIS, overview of general and specific challenges

When relevant, setting-up a health micro-insurance scheme consists in organising the provision of health insurance benefits tailored for excluded groups as characterised earlier in Part one.

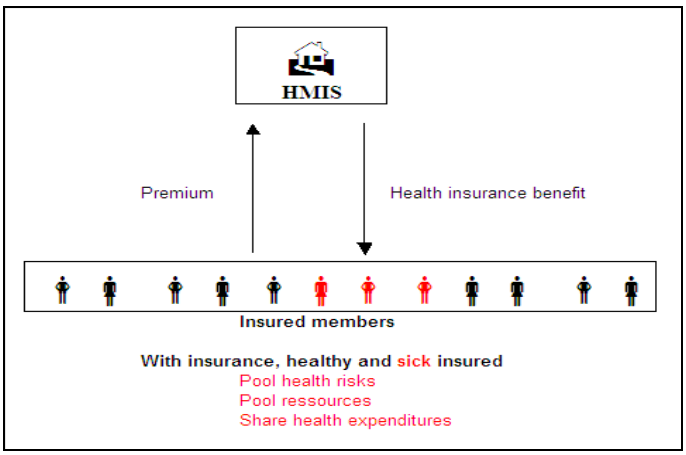
Health insurance benefits can take several forms such as:

- Full or partial reimbursement upon invoice of the cost of a given set of health services when needed in any health care facilities;
- Full or partial reimbursement upon invoice of the cost of a given set of health services when needed in selected health care facilities contracted by the HMIS;
- Free access or access with a co-payment* to a given set of health services in selected health care facilities contracted by the HMIS;
- Provision of a lump sum payment upon control when insured face a given set of health risks.

Health insurance benefits are to be accessible for insured persons against the prior payment of a premium and under pre-defined conditions of membership and access to health services.

Health insurance premiums are expected to cover the expenses of the HMIS.

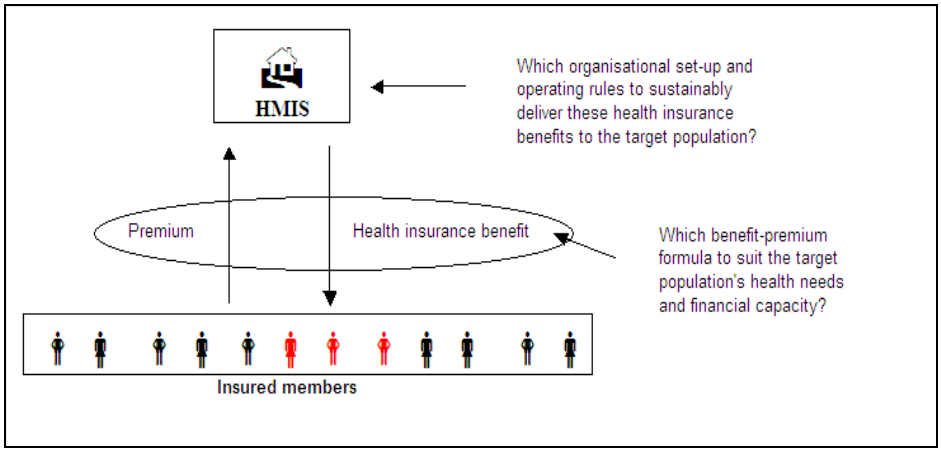
When voluntarily enrolling in a HMIS, insured members accept to pay a regular premium to buy the certainty to access adequate health services and avoid catastrophic expenditures when they face a given set of health risks. Moreover, following the insurance principle, insured members accept to share health expenditures between sick and healthy insured.



General challenges

Organising the provision of health insurance services tailored for excluded groups involves designing one or several benefits-premium combinations (package or formula)* as well as defining the organisational framework and operating rules that can guarantee the viable provision of health insurance services and access to health care services as defined in the benefit packages.

Designing the benefit package consists in defining which health services (and other services) will be covered by the HMIS; which level of benefit will be given to insured when they need those health services; under which conditions: membership rules; level of premium to be paid and other conditions to access health insurance benefits (such as conditions to access health services covered).



Conceiving the HMIS organisational framework and operating rules consists in defining who will manage HMIS' core operations (distribution and marketing ; enrolment ; premium collection ; claims management -including health services' provision-), as well as standard managements tasks (accounting ; financial management ; monitoring of activities; control of procedures ; Human resources management), and how.

In reference to expected capacities for a sustainable HMIS identified in *Health micro-insurance schemes: monitoring and evaluation guide, ILO/STEP and CIDR, 2001*, eight major capacities/ functions that promoters have to consider when designing HMIS organisational structure are described in the following table.

FUNCTION/ CAPACITY	DESCRIPTION
(1) Distribution and Marketing	One of the first tasks for HMIS promoters (managers) is to ensure that members are informed of the insurance benefit, engaged to join the plan on a continuous basis and understand how to access benefits. Joining a HMIS represents an intangible benefit, a promise of a future benefit in the event of certain illnesses, provided premiums are paid in advance. The establishment of solid communication and distribution methods is therefore of critical importance to engage and retain the membership participation. *Marketing* focuses on the design of new benefits packages (targeting for instance new groups of population) and the updating of existing packages in line with actual and potential members' expectations (coverage of new services, increase in the levels of coverage, etc.). Surveys should therefore be conducted to seek the level of satisfaction of present members, reasons for not renewing membership, and assess potential members' coverage priority needs. *Communication* includes various activities that require constant refreshing. Examples of activities include: external communication on the scheme (through newspapers, web sites, meetings, etc.); communication towards the members on the scheme's activities, financial results, new initiatives, etc.; production of comprehensible and simple leaflets on the benefits package(s) and supplementary services of the scheme; etc.
(2) Membership management and monitoring	Enrollment and membership management involves the following activities: - Enrolment of members (recording in insured registers/files); - Renewing the contract (when applicable); - Application of the premium scale; - Establishment and signature of the contract; - Preparation of the insurance certificate/receipt or membership card. With the use of appropriate tools and *Monitoring and Information System*, HMIS managers have to know at any time: - The identity and number of beneficiaries (members and dependants); - Periods of coverage of beneficiaries; - Members in arrears with their premiums; - Members temporarily or permanently excluded.
(3) Premium collection	Collection of premiums and membership fees (if applicable) involve the following activities: - Collection of amounts due; - Collection of amounts paid in installments monitoring; - Debt collection; - Recording and issue of supporting documents (receipts, etc.).
(4) Claims processing and health care providers	HMIS may reimburse health care to insured persons or pay/reimburse health providers for health services used by insured members (in the case of a third party payment agreement). In either case the reimbursement has to be done as fast as possible to members or health care providers. Poor service will result in higher lapses of members or non-cooperation of health care provides.

	Claims management requires the following activities to be carried out by the HMIS: - Verification of entitlement to benefits*; - Issue of guarantee letters (when applicable); - Control of health care providers' invoices; - Reimbursement and / or payment order and payment (when applicable with Third party payment mechanism). * With third-party payment agreement, health care providers are also usually involved in verification of entitlement to benefits.
(5) Management procedures **(Monitoring of activities and control of procedures)**	A HMIS has to put in place appropriate management procedures to respect insured members contracts and achieve HMIS development objectives: - business plan and annual plan - guide of procedures - monitoring and information system - internal audit and control systems - human resources management - health care quality audit (quality control) - insured members' satisfaction survey questionnaire
(6) Quality of Risk Portfolio	A portfolio consists of a set of contracts, which are in turn composed of a series of benefits or risks covered. The risk portfolio is the entirety of current contracts, i.e. all insured persons covered and risks covered. A HMIS has to ensure that the quality of its risk portfolio is high i.e. that no major dysfunctions arise from adverse selection and moral hazard (over-consumption and over-prescription – see definitions pages _). Risk portfolio monitoring involves checking for changes in the various components of the cost of the insurance product. It also allows reviewing the level of the premium (*pricing activities*) to match changes in the average cost of claims by the HMIS as well as changes in the frequency of risks (see section II.2._Calculating and setting premium).
(7) Financial Statements	A HMIS must have an accounting system that allows producing for any given period, accurate standard financial statements: - Income (and expenditure) statement; - Balance sheet; - Cash flow statement.
(8) Cash flow monitoring and investments	Good financial management of the HMIS requires forecasting and planning, with precision, the future income, expenses and investment maturities of the MHIS. This forecasting involves preparing the budget and the cash flow plan. Should the HMIS have surplus funds greater than one-year expenses, an investment policy should be established. The elements of the policy should be diversification of investments and quality of permissible investments.

Sources: based on and adapted from *Health micro-insurance schemes: monitoring and evaluation guide, ILO/STEP and CIDR, 2001.*

Overall, when setting up a HMIS, the adopted benefit-premium package and organisational set-up will have to ensure that the HMIS is administratively, technically, functionally, financially and economically viable[16].

Administrative viability calls for an appropriate monitoring of the health insurance scheme's core administrative functions:

- Distribution and marketing;
- Membership (production of the insurance contract);
- Collection of premiums;
- Claims processing;
- Monitoring of the risk portfolio.

Technical viability requires to manage appropriately health insurance related risks[17]:

> ***Adverse selection:*** a phenomenon according to which persons with a greater-than-average risk of illness or maternity enroll in a health micro-insurance scheme in a higher proportion than that of their share of the target population and/or choose the highest levels of coverage. When individuals have no say about whether to be insured or at what level of coverage, adverse selection does not exist. Such is the case when membership is automatic and schemes offer a single level of benefit. The existence of adverse selection may jeopardize a scheme's financial viability with benefit-related expenses risk exceeding forecasts that are based on estimates of consumption for the overall target population.
>
> ***Moral hazard :***
> (a) Over-consumption (demand side moral hazard)[18] : A phenomenon according to which insured persons take undue advantage of health services covered by the scheme because they know they are insured against the cost of such services. Their utilization of health care exceeds the pattern of utilization used as a basis for determining premiums.
>
> (b) Over-prescription (supply side moral hazard): A phenomenon according to which health providers adjust their prescriptions to correspond to patients' maximum level of coverage, without opposition from patients, given the fact that the latter know they are

[16] For extended explanations consult: *Health micro-insurance schemes: monitoring and evaluation guide, ILO/STEP and CIDR, 2001.*

[17] Consult annex n°_ for a summary table of measures that might be used to manage health insurance related risks.

18 In low income contexts, one can argue that over- consumption is expected to be limited as most of the insured patients face substantial opportunity cost to access health care as mentioned in part one.

covered. Health providers may have a tendency to prescribe more medicines than necessary, lengthen hospital stays, systematically use diagnostic tests, such as laboratory analyses, x-rays, etc.

Catastrophic risks : Contingencies that affect a large segment of the covered population, such as epidemics, and/or those for which the unit costs are high, such as a very costly hospitalisations. The occurrence of catastrophic risks may jeopardize the financial viability of a health micro-insurance scheme.

Fraud and abuse: Individuals who do not pay any premium to the HMIS, and therefore who cannot benefit from health insurance services, may take-up the identity of those entitled in order to receive benefits without paying for them.

Functional viability requires to ensure that the basic principle of insurance, namely providing the designed benefits in return for premium are respected.

Financial and economic viability requires to ensure that the scheme's expenses are covered from the scheme's resources in the long term.

Insured premiums constitute the primary source of revenue for insurance scheme. Collected premiums must be sufficient to:

(1) finance health services and other services covered by the scheme and used by insured (claims expenses);
(2) finance the operating costs of the scheme (including fixed and variable administrative expenses as well as distribution and marketing expenses : wages of the salaried staff, office rent/ travelling costs, office equipment, stationary/ training workshop for HMIS promoters, promotional tools for the enrolment campaign, etc.);
(3) generate a surplus in order to accumulate financial reserves and ensure the scheme's growth and sustainability.

Setting-up a financially viable health micro-insurance scheme requires enrolling a large number of persons. Since the individual premium is calculated based on morbidity rates and health services' costs average figures for the general population, a sufficiently large number of insured is necessary to keep up with these averages and build a financially accessible and viable HMIS.

Besides premiums, a HMIS may mobilise temporarily or permanently additional sources of revenue such as :

- membership fees (also called enrolment or admission fees) that is usually paid once only, when the member joins the health micro-insurance scheme, and is therefore not payable in subsequent years;
- subsidies or donations from the mother organisation (e.g. MFI), national or local government or external development partners (e.g., donor agencies, NGOs);

- revenues from income generating promotional activities (raffles, cultural events, etc);
- revenues from services charged to external users when HMIS own specific accommodations for patients relatives and/or transportation services.

A clear and efficient governance structure as well as an appropriate managerial capacity will be necessary (but not sufficient as external factors will have to be accounted for) to achieve and sustain those four levels of viability.

Specific challenges

Beyond general challenges associated with the setting-up and functioning of any insurance scheme, setting-up a HMIS will require matching excluded groups' health needs[19] as well as fitting within their limited financial capacity. When designing the scheme's benefit formula(s) and organizational set-up, those requirements will inevitably involve making challenging tradeoffs between :

- ***Affordability:*** maintain the premium level as low as possible in regard to the target population's capacity to pay;
- ***Acceptability (attractiveness):*** provide the most comprehensive benefit package according to insured members' point of view;
- ***Efficiency:*** make the best use of collected premiums i.e. actually protect insured members against catastrophic expenditures and inappropriate financial access to health care (efficiency objective will require to set appropriate rules to manage health insurance related risks);
- ***Equity:*** ensure equitable access to the scheme, notably facilitate large and poorer families' enrolment;
- ***Administrative flexibility:*** provide sufficient flexibility to suit excluded groups income generating activities and cash flow patterns to ease enrolment and premium collection (decentralised marketing and collection of premium);
- ***Administrative simplicity:*** adopt simple administrative procedures that can be understood by generally rather low-educated population, that can fit with limited management capacity and contain management costs;
- ***Transparency:*** ensure that insured members are regularly informed on the use of their premium to create and maintain confidence with insured.

For each HMIS promoter, facing those general and specific challenges will result in a specific product design and organisational set-up as demonstrated by the actual diversity of existing HMIS. Based on in depth case studies conducted by STEP/ILO in Asia and Africa, case study

[19] A travailler : il faudrait dire en quoi ils sont spécifiques : généralement plus de besoins car santé négligée avant d'être assuré ? à mettre en cohérence avec le chapitre 1.

boxes will be given along that chapter to illustrate HMIS's diversity regarding product and organisational designs[20].

Moreover, as setting-up a HMIS involves to deal with a certain level of uncertainty notably regarding insured behaviour towards health care utilisation and management costs, it can be expected that the setting-up of a HMIS will generally go through an iterative process more than a linear one (see part III). Most of HMIS go through adjustments in their design and functioning after the launch of their activities. However, the critical challenge for HMIS promoters will be to start with an optimal product and organisational designs since the very beginning.

II.2 Setting-up a HMIS, product design challenges

The HMIS product's design is the cornerstone in the setting-up of the scheme. It consists in selecting health services that will be covered, the level of financial coverage that will be guaranteed and the conditions under which health insurance benefits will be provided to insured: membership conditions, level of premium to be paid and other conditions to access the covered health services.

II.2.1 Which membership rules?

Designing the membership conditions of a HMIS consists in clarifying who are the beneficiaries of the scheme. It requires defining clearly who can join the scheme (member) under which conditions (membership criteria and affiliation periodicity) and who will benefit from the defined health insurance services (member and dependants).

[20] Consult ILO/STEP website to access HMIS cases studies.

Possible options and overall challenges when designing HMIS membership are summarised in the box below.

Checklist box
Designing HMIS Membership_ options and challenges

HMIS membership is voluntary. It may be:
- ❑ Individual, family-based or collective
- ❑ Automatic or not
- ❑ Restricted or not
- ❑ Cancellable

HMIS enrolment period may be:
- ❑ Open (on-going enrolment over time)
- ❑ Closed (enrolment during a limited period of time)

In defining membership and enrolment rules, major challenges for HMIS promoters will be to weigh any option s' choice against the need to:
- ❑ Encourage enrolment and renewal
- ❑ Fit with the target population's cash flow pattern to be financially accessible
- ❑ Limit adverse selection
- ❑ Avoid complex procedures for both insured members and HMIS managers
- ❑ Limit management time and cost burden for HMIS

Membership arrangements

As stated in part I as a core characteristic, HMIS are voluntary insurance schemes. As such, they are particularly exposed to:

(1) Adverse selection (see definition box n°) that may endanger the scheme's financial viability; with actual claims exceeding forecasts.

(2) The necessity to be highly responsive to people's needs in order to attract and keep a large enough membership pool to remain affordable.

In that regard, the **challenge** when designing the membership rules will be to select appropriate options to **ease the target population's access** in order to **encourage large enrolment** while **controlling for adverse selection** as well as **limiting management procedures**.

Membership in a health micro-insurance scheme may be of the following types:
- Individual: each person may join on an individual basis;
- Family: all members of a family must be enrolled;
- Collective: the employees of an enterprise or the members of a cooperative join collectively and not as individuals.

Individualised membership is easier to implement and generally more easily accepted by the target population as they can adapt the number of persons to be enrolled according to their capacity to pay at the time of registration. However, individualised membership entails a major risk of adverse selection since the members may tend to enrol in priority dependants with high health or maternity risks (e.g., pregnant women, the elderly, sick persons, new born children). It will be therefore require introducing appropriate waiting period and increasing the premium.

On the contrary, ***family-based and collective membership*** enable to limit adverse selection (for example if all members of the family have to join, persons with high health and maternity risks are compensated by persons with low risks). Remarkably, ***family-based membership*** does not encourage discrimination between members of a family in accessing health care. However, it requires adopting a clear definition of the family that matches cultural acceptance and can be controlled during the enrolment process. In Bangladesh HMIS, such as BRAC and Grameen Kalyan health program, have adopted the practical definition of "people eating from the same pot" to define the membership unit. As a new official family book is available in Cambodia, SKY GRET HMIS refers to the official register when enrolling families. The case of insured newborn must also be addressed in designing membership criteria.

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

- ***Voluntary***. The decision to join a health micro-insurance scheme is taken by each individual or each family;
- ***Automatic.*** Belonging to a group (cooperative, village, trade union, enterprise) or concluding a contract, such as a request for credit from a microfinance institution, automatically entails membership in a health micro-insurance scheme. The decision to join the scheme is not taken by the individual, but by the group to which he or she belongs or the institution of which he or she is a customer;

Automatic membership has two major advantages: it may limit the risk of adverse selection and it enables the scheme to gain a large membership within a short period. On the other hand, automatic membership may contribute to reduce the sense of individual responsibility. If appropriate mechanisms are not introduced, automatic membership may provide a greater ground for moral hazard (over-consumption), frauds and abuses as individual insured will have little sense of ownership over the premium fund.

Experiences reviewed tend to show that automatic membership may be rather difficult to enforce (see case study box n°).

NB: As defined earlier, compulsory membership is not applicable to HMIS since it refers to the situation of individuals, families or groups who are compelled to join a scheme without having made this decision themselves. This is the case with many wage-earners who are required to join a social security scheme, for example.

Membership restrictions

In any schemes, it will be essential to clarify the membership criteria as well as the definition of dependants and the means to control that those criteria are actually observed.

- HMIS promoters will have to define precisely who can join the scheme as a ***member*** and hold the responsibility to respect the rules governing the operation of the scheme and the insurance contract conditions (rights and obligations) and notably who will pay the initial membership fee (if any) and the premium on a regular basis.

- HMIS promoters will have to clarify who can be considered as dependants and can beneficiate from the insurance coverage acquired by the member. ***Dependants*** are usually the spouses and legitimate, natural or adopted children up to a certain age (adulthood age) or any other person dependent on the member according to the rules defined by the scheme. In the absence of official definition and to take into account cultural factors, a practical definition may have to be adopted. When extension of benefit to dependants (including newborn) is considered, it will have to be taken into account in the premium calculation (see section II.2.2 .2 for details).

In some schemes membership criteria may include restrictions on age (e.g., only persons below 65 years old can join the scheme) or on health status (e.g., only persons in good health conditions can join). These restrictions aim to limit the risk of adverse selection. This is the case of most commercial insurance schemes. Such restrictions on membership are generally contrary to the mission of HMIS and may be questioned for ethical or social reasons. Alternative measures exist to address adverse selection that should be favoured instead of membership exclusions (see annex n°_ for details).

Conditions of withdrawal and termination

When designing membership rules, HMIS promoter will have to plan for cancellation rules while discouraging opportunistic behaviour and encouraging members to remain insured.

The member should be able to leave the scheme and/or to cancel one of his/her dependants. In order to avoid opportunistic behaviours, many schemes introduce a closed cancellation period (e.g., only at the anniversary of their affiliation; on the 1st of January) or tough cancellation procedures (e.g., send a letter at least one month before the cancellation starts). Similarly, the scheme should be able to cancel the affiliation of a member or any dependant under certain circumstances such a premium default payment after a given grace period or in case of obvious frauds or abuses, etc.

Enrolment period: open or closed

HMIS promoters will have to define if the affiliation to the scheme will be open (open enrolment) or only possible during a given period (closed enrolment). When deciding on that issue, HMIS will mainly have to balance accessibility of the scheme against its management complexity.

A ***closed enrolment*** (or renewal) period reduces the risk of adverse selection, since there are little chances that the potential members join the scheme (or renew) at a period where they forecast important health care expenses. It contributes also to simplify management: the collection of the premiums can be concentrated within a short period; workload related to monitoring and controlling memberships is reduced. However a closed affiliation period may not be satisfactory as it reduces the dynamic of affiliation.

Proposing an ***open enrolment*** highly increases the accessibility of the scheme and boosts the growth of the insurance pool as potential insured can join as soon as they have enough cash to pay the premium. Open affiliation associated with split payment of the annual premium may further reinforce the accessibility of the scheme. However, open enrolment favours adverse selection and therefore requires introducing appropriate waiting periods* (see definition page_ and annex n°_). When associated with premium split payments (e.g. monthly payment after registration and an initial payment of three months), open enrolment does require sufficient management capacity to ensure appropriate monitoring and follow up of the premium payment and avoid jeopardizing the financial viability of the scheme.

Case Study box – illustrating HMIS diversity
HMIS Membership criteria and rules

In the Philippines, ***Novadeci Health Care Programme***[21] is open to Novadeci cooperative members. It has introduced an age requirement (being under 55 years old), and members or dependants that are above 55 years old are excluded from the scheme (they may then receive assistance from Novadeci's old age and disability pension programme). At the beginning of the programme, pre-membership physical examination was also required but has been waived as it was identified as a major hindrance to access the scheme. In order to keep on limiting adverse selection, it has been replaced by a 2-year waiting period for specific types of illnesses. In 2001, in order to increase the number of members and dependants, the management decided to make the membership evolve from voluntary to compulsory for the cooperative members. This decision apparently was not implemented since it did not find enough support from the members.

In Cambodia, ***GRET SKY HMIS***[22] has adopted a family based membership following the civil family register no additional criteria has been set beyond the residency in the villages where the scheme is active. After a first period without any waiting periods required in order to ease the access to the scheme and demonstrate its utility to the target population, the scheme has introduced appropriate waiting period for the coverage of delivery and hospital care to address adverse selection before the scheme start its geographic extension. An automatic membership is given to insured new born for a given period when the mother has followed all required prenatal consultations and if post natal consultations and vaccinations for the newborn. After the given period, the family will have to pay the premium for the newborn.

In India, in Gujarat State, ***Wimo-SEWA***, the health insurance part of SEWA Integrated Insurance Scheme (ISS) developed by the Self Employed Women Association the membership is reserved to the women members of SEWA. Membership's criteria require being a woman member of SEWA, who opens a bank account in SEWA bank, is under 58 years old and pays an annual premium or make a fixed deposit. The woman member can choose to extend or not the health insurance coverage to her children and husband by paying additional premium. When SEWA integrated insurance scheme (IIS) was set up, membership was designed as automatic without informing the members that were not aware of their entitlement. Consequently, they had not been aware of their entitlement to claim and thus were unwilling to pay the premium. The change from compulsory to voluntary membership of the scheme in 1993 caused a sharp decline of the membership (from 38,136 members in 1993 to 7,000 members in 1994).[23]

Also in India, in Karnataka State, ***Yeshasvini[24] health plan*** (health insurance scheme) has been set in partnership with the Karnataka State co-operative Department to reach farmers through the well-developed cooperative network. The membership criteria required farmers to be registered for at least six month in a cooperative and be under 75 years old. Paying additional premium for their spouse and two children maximum can extend health insurance coverage. This membership criterion was encouraging parents to enrol only children that have high probability of needing health care and adverse selection has been observed from the second year of activities. Yeshaswini is considering the feasibility to require family membership to reverse this dangerous trend.

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[21] ILO/STEP: 2001. *The Novadeci Health Care Programme,* Case study.

[22] Reference

[23] ILO/STEP: 2001. *Women organizing for social protection. The Self-employed Women's Association's Integrated Insurance Scheme, India.*

[24] Garand D. ILO/STEP 2005. *Review of the Yeshasvini rural micro insurance scheme in India*.

Some suggestions regarding membership (?)

As far as possible, family-based membership should be favoured as it does limit adverse selection without encouraging counterproductive selection between members in a family in regard to the objective of improving access to health care for excluded households.

However family membership may render the total premium unaffordable for large families. HMIS promoters will therefore have to consider family premium packages to allow for cross-subsidisation from small to large families (see section II.2.2.2).

Exclusion on health status and age should be avoided and related adverse selection risks should be addressed by exclusions on specific health services and/or by appropriate linkages with existing public health programs (Tuberculosis, HIV-AIDS, Malaria programs for examples).

Open enrolment may also be favoured once appropriate human resources and tools are in place to ensure an efficient management and monitoring. In rural areas, open affiliation has to be weighed against its management requirements since close affiliation might be appropriate to fit rural households cash flow pattern.

In all cases, context matters!

II.2.2 Which health insurance benefit - premium formula(s) ?

Designing the health insurance benefit/premium formula will require making a trade-off between the target population's needs and demand, its capacity to pay and to understand the services and the availability and functioning of health services. The level of exposure to health insurance related risks, as defined earlier, will also have to be considered when selecting health services to be covered.

Options and challenges that HMIS potential promoters may have to consider when designing the benefit/premium formula are summarised in the following checklist box n°_.

Check list box n°_
Benefit / premium formula design _ options and challenges

Select health services (and others) to be covered:
Basic or primary health care services
Hospital care for medcial and surgical treatments
Specialised care and prosthesis
Diagnosis exams
Drugs (generic, brand name drugs) and consumables
Transportation for referral

Calculate the premium associated with the selected health services

Define the level of coverage:
(1) Co-payment or not (1bis)
(2) Limitations or not (2bis)
(3) Deductible or not (3 bis)

(1bis -2bis -3 bis) to ease access and protection
(1-2-3) to limit level of premium
(1-2-3) to limit moral hazard

Define exclusions:
(4) Services / illness exclusions

(4) to limit financial consequences of insured with high health and maternity risks -to limit premium level

Set conditions of eligibility to access health services:
(5) Third party payment or not (5bis)
(6) Waiting period
(7) Prior agreement
(8) Mandatory referral
(9) Therapeutic protocols

(5) to actually remove financial barriers to health care
(6-7) to limit advserse selection
(7-8) to limit moral hazard (over consumption)
(8-9) to encourage rational use of health care
(9) to control quality of health care

Elaborate benefit/premium package(s):
(10) One benefit package
(11) Several benefit packages

(10-11) to fit with Social Security package if any
(10) to keep the system simple
(11) to suit different sub-category of population
(11) to generate self selection

When designing the benefit/premium formula, the challenge will be to:
Provide a relevant and attractive protection against illness and maternity financial risks
Balance the relevance and attractiveness of the BP with its affordability (premium level)
Limit insurance specific risks (advserse selection, moral hazard, catastrophs, fraud)
Keep the benefit package simple to understand
Limit management complexity

II.2.2.1 Selecting health services to be covered

An insurance coverage of all types of health care and services would require an excessively high contribution (premium). Since target population's ability to pay* is usually low, it is most often necessary to short-list the services to be covered by the scheme.

Generally, one of the first decision to take for HMIS promoters will be related to the inclusion or not of ***minor risks*** in addition to ***major risks*** in the benefit package.

The coverage of minor risks by a health micro-insurance scheme is principally aimed at promoting timely access to health care in order to prevent a decline in the health status of sick persons. However, this type of coverage must contend with two major constraints:

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

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

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

Ideally, HMIS may try to cover both categories of health services associated with exclusions. The benefit package will have to be clearly detailed beyond the general "major- minor risks"

categories and take into account health providers' invoicing method (see section II.2X) [25].

Non medical services, such as transportation services when insured patients are referred, may be part of the benefit package. It will generally be of critical importance in HMIS active in rural areas where distance and absence of transportation facilities may dramatically hinder access of health care services even if these latest are free of charge.

Definition box n°_
Categories of health services that might be considered for coverage

- ***Basic or primary health care services***

- Preventive and promotional care (such as pre- and postnatal consultations, monitoring of healthy infants, immunization, family planning, health and hygiene education);
- Curative care such as consultations, nursing care for minor ailments;
- Follow up of chronic ill patients and related treatments (e.g. Tuberculosis);
- Observation (minor hospitalisation) for assisted delivery and before referral to hospital.

- ***Hospitalisation i.e. hospital care for medical or surgical treatment*** (may include drugs, diagnostic exams, accommodation during the stay in hospital).

- ***Specialised care and prostheses*** (hospital based or within a private practice)

- Specialist consultations (gynaecologist, paediatrician, surgeon, etc.);
- Dental care i.e. dental treatments (e.g., dental caries), surgery (e.g., extractions), radiology and dental prosthesis (e.g., dentures).
- Eye glasses i.e. glasses and frames.

- ***Diagnosis exams*** (that may be included or not in other health services fees) i.e. laboratory exams, radiology, ultrasound scans;

- ***Drugs and consumables*** (that might be included or not in other health services fees):

- Drugs: generic and brand name drugs;
- Medical consumables include medical or surgical kits (tubes, drips, syringes, bandages, etc.) that might be charged to patients.

- ***Ambulance*** or other transportation services for emergency referral.

Source: adapted from Health micro-insurance schemes: Feasibility study guide, Volume 1: Procedures, Volume 2: Tools, ILO/STEP, 2005.

[25] For details, also consult ILO/STEP (2005) Health micro-insurance schemes: Feasibility study guide, Volume 1: Procedures, page 48 and volume 2: Tools, page 126.

Overall, before considering the target population's capacity to pay the associated premium, four priority criteria may guide the selection of health services to be covered[26]:

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

II.2.2.2 Calculating and setting the premium[27]

As already explained, premiums are the prime source of revenues for HMIS. Calculating and setting an appropriate level of premium will be of critical importance to ensure the financial viability of the scheme.

Some options and challenges that HMIS promoters may face when calculating and setting the premium, are listed in the box below.

[26] Source: Health micro-insurance schemes: Feasibility study guide, Volume 1: Procedures, Volume 2: Tools, ILO/STEP, 2005. Philippe, Valérie : cette partie est identique à la partie écrite par Valérie dans le guide de faisabilité. Est-ce un problème ? dois je en faire mention ou bien ce n'est pas nécessaire puisque c'est la même « maison » ?

[27] Philippe, Valérie : idem pour la partie expliquant le calcul de cotisation .

Checklist box
Calculating the premium_ options and challenges

Beyond academic actuarial calculation, HMIS premium may be set based on:
- ❑ Forecasted/targeted consumption of selected health care services (health benefit is adjusted to needs and priorities)
- ❑ households capacity to pay (and benefit package is adjusted in consequence)

Premium can be set as:
- ❑ An individual premium
- ❑ A global family premium package
- ❑ Intermediate types of premium package (different family size package)
- ❑ An income-based premium

Premium can be paid in one or several instalments:
- ❑ Annual payment
- ❑ Monthly payment
- ❑ Daily payment
- ❑ Other frequencies of payment

In calculating and setting premiums, challenges for HMIS promoters will be to:
- ❑ ensure that claims expenses and operating expenses to deliver the selected benefit package are covered
- ❑ encourage poor and large families' membership

Calculating the premium

This guide does not intend to give extended details on how to calculate premium and the different formulas that might be used. It will give an overview of the standard components that should be accounted for when calculating the premium, and the different approaches that may be used to set the premium.

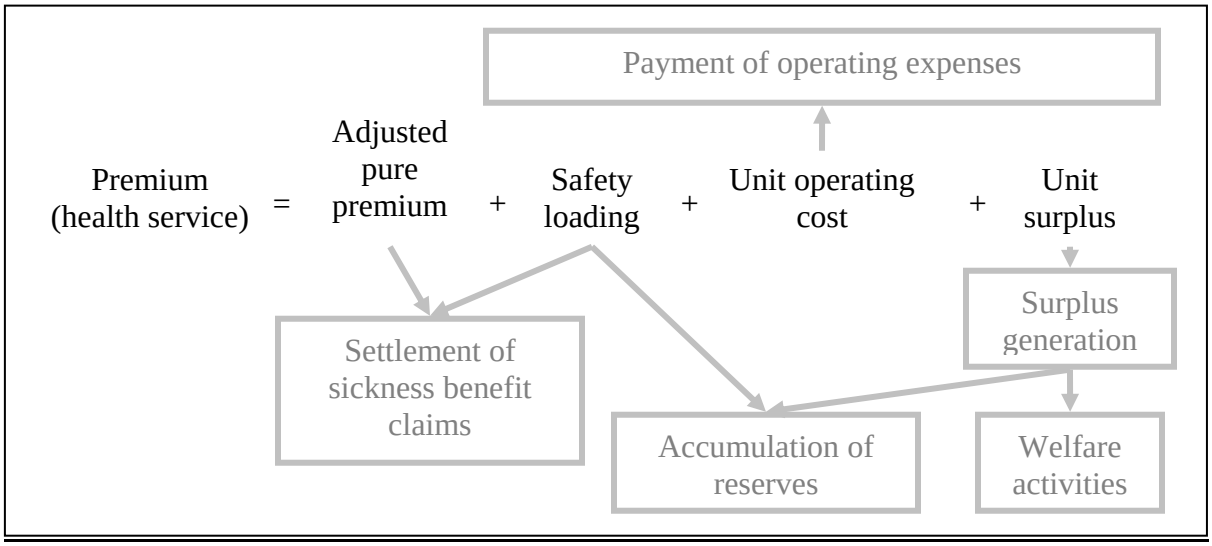
Premiums are calculated on a yearly basis.

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

The individual premium for a given health service is equal to the sum of the following elements[28]:

- *The corrected gross premium.* The gross premium is the annual average cost of the benefits package for each service covered. It is calculated for a standard or average individual. It can then be corrected in order to take into account factors that have an influence on the health care expenses such as age, sex, location (near or far away from health care facilities), occupation (since some occupational groups are more exposed to health risks), etc. The gross premium can also be corrected to take into account the impact of certain services and mechanisms that may contribute to increase or decrease health care expenses (e.g., direct payment mechanisms, health education programmes, waiting period to establish eligibility for coverage).
- *The safety factor*: it is added to the risk premium and allows for the risk that the real average costs incurred by insured persons may exceed forecasted amounts; this risk is all the more so important as the size of the membership is small.
- *The unit operation costs*: it corresponds with the annual operation costs of the health micro-insurance scheme per person covered.
- *The unit surplus*: it is the amount of annual surplus per person covered necessary in order to build up a reserve fund.

Total individual premium is then obtained by adding up individual premiums per service.



[28] Another method of calculation of the total individual premium consists of assessing future operating costs of the partner health care provider and dividing it by the expected number of users. This method – which is only appropriate to certain cases - is explained in detail in the chapter 4 in *Health micro-insurance schemes: Feasibility study guide, Volume 1: Procedures /STEP, 20*

Calculating the premium may usually appear as a difficult task since required data (such as frequency of diseases and average cost of health services) may not be neither available nor reliable.

During the first year or first months of activities of the scheme, premium might not be set according to academic calculation but might be set based on targeted consumption of health services and average costs of health services or simply based on households capacity to pay. If such approaches are adopted, HMIS promoters should plan for a specific financial fund to secure the launch of the scheme. Most importantly, a rigorous monitoring of claims will be necessary to adapt, as fast as possible, the level of premium in order to ensure the financial viability of the scheme (see part III .1.5).

Setting the premium

Once individual annual premium for a given benefit package is calculated, several options may be adopted to set the premium for insured.

There are a variety of ways to set premiums:

- ***Individual premium***: each person, whether member or dependent, pays the same premium amount. Alternatively, each person pays a premium, but dependent's premiums are lower than those of members. Premiums may also be determined on the basis of individual characteristics, such as age, sex, state of health, place of residence or occupation.
- ***Global family premium***: a single premium is paid, irrespective of the number of dependents in the family.
- ***Intermediate types of premium***: the "single/family" premium, with one premium level for single persons without dependents and another for families, irrespective of the number of dependents; or several premium levels depending upon the size of the family such as "single person premium", "medium family premium" and "large family premium" with single person paying proportionally more than large families.
- ***Income-based premium***: the premium level is proportional to income, with the possibility of establishing a ceiling.

Premiums may be paid in a variety of ways: daily, weekly, bi-monthly, monthly, quarterly or by trimester, bi-annually, annually, etc. The health micro-insurance scheme can:

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

For any premium setting's options, the constraint is to ensure that the set level of premium is sufficient to cover the cost of the claims and the scheme's operating expenses while limiting management complexity. Premium settings should be consistent with membership adopted arrangement. For any options, HMIS promoters should also examine equity implications i.e. does the premium setting option ease or not the enrolment for poor and large families in the target

population.

Updating levels of premium

Beyond the launching period, a critical task for HMIS managers will be to regularly review premium calculation (for instance, each year) on the basis of predetermined indicators such as claims ratio*, inflation rate, etc. (see part III .1.5).

II.2.2.3 Selecting the optimal health insurance benefit – premium formula

Overall, HMIS promoters may keep four major criteria in mind when designing the benefit package. Selected health care coverage should be:

- Relevant;
- Visible;
- Financially affordable;
- Allowing to control for health insurance related risks.

Health care coverage must be relevant

Services felt as most useful by the population may be different from services that are useful for the improvement of individuals' health status (services that succeed in reducing significantly mortality and morbidity rates, such as preventive and promotional care) and therefore limit health expenditures. For example, excluded groups who faced under-use of health care will generally ask for the coverage of branded name drugs beyond generic drugs and high technology diagnosis exams such ultrasound scans within the maternity package.

It will be critical to consider both points of view when designing the benefit package in order to check its relevancy in regard to a public health approach. In that respect, it will be equally essential for HMIS promoters to have a solid understanding of:

- The target population's needs and demand and, in that regard, adopting a participative approach for the benefit package's design will be determinant (see part III);
- The epidemiological pattern (burden of illness, "major killers") and the standard protocol treatments related to major illnesses in the context;
- The health financing issues faced by health providers (under-used services, overloaded services, services with high default payment rates).

This last point is not exclusively aimed at health providers that might be willing to develop health micro insurance services. It is aimed at all potential promoters as it will give valuable knowledge to understand health providers' stand point which will be most critical when negotiating contracts' conditions with them (see contracting with health providers in section II.2.3).

Discussion box
Essential but comprehensive coverage

Including basic health care services, that does make sense from a health point of view and to make insurance advantages visible, may however render the benefit package unaffordable for the target population. The challenge for HMIS promoters will generally be to try identifying and selecting “essential health services” for both primary health care and hospital care in the benefit package while keeping the associated premium affordable.

As many public health systems in developing countries are trying to concentrate on delivering an essential package of activities within public health facilities (Minimum Package of Activity, Complementary Package of activities). one approach in defining the benefit package in such contexts may consist in covering available services defined in the essential health services package at the different levels of the public health system and set some exclusions. This approach may be particularly relevant in rural areas where public health facilities are very often the only available health structures HMIS can contract with.

When formal social security health insurance benefit exist for civil servants for example, the challenge for HMIS may also be to define a benefit package close to that existing package. This approach might be favoured in HMIS that have strong link with Ministry of Health or social affairs.

Health insurance benefit must be visible

As membership is voluntary and insurance mechanism’s advantages will generally be poorly known within the target population, it will be critical for HMIS to propose an attractive benefit package, essentially a visible benefit. At least during the starting phase, the target low-income population will generally be looking for an immediate return on their premium.

Including basic health care services or more generally minor risks coverage (such as curative consultations, drugs, laboratory tests) can significantly contribute to increase HMIS attractiveness.

In addition, dedicating a part of HMIS resources (from premium or additional sustainable sources if any) to the provision of visible public benefits as well as specific non-monetary advantages for insured may also contribute to increase HMIS visibility. It also may also give satisfaction to insured members that are healthy and do not benefit from the scheme services as sick insured persons do.

Depending on the context, different activities might contribute to increase the scheme’s visibility (and also efficiency) and encourage healthy persons to remain insured:

- installing fans or television with health education programs in the waiting rooms in partners’ health providers with the HMIS logo;
- organising health education meetings aimed at insured;
- systematically providing impregnated free bed nets for all insured pregnant women ;

- when relevant, organising specific access to a specialised doctor at primary level on a monthly basis for insured (paediatric doctor, gynaecologist, etc).
- etc.

Including basic health care services, that does make sense from a health point of view and to make insurance advantages visible, may however render the benefit package unaffordable for the target population.

The associated premium must be affordable

When selecting health services, HMIS promoters will have to weigh a given decision against its impact on premium level and check that the latter remains affordable for a large proportion of the scheme's potential members.

The level of the premium should not exceed households' willingness to pay and ability to pay.

Definition box
Willingness and ability to pay

Willingness to pay depends essentially on individuals' level of income and their perception of the risks: the greater a person's aversion to risk[29], the more he or she will be willing to pay.

An individual's ***ability to pay*** is the maximum amount he or she is capable of paying; it is therefore linked to income.

Ability to pay is always greater than or equal to willingness to pay, even for persons with a significant aversion to risk. In a context of poverty, however, the levels of ability to pay and willingness to pay are both very low and tend to be indistinguishable from one another.

Ability and/or willingness to pay may be assessed within the target population (for instance through a households' survey) before setting the level of premiums.

Besides, the level of the premium should not exceed a certain percentage of the average income.

If the premium level required for covering a particular package of services at 100% of expenses incurred is too high, several alternatives will have to be explored such as:

(1) Some health services may be excluded from the benefit package;
(2) The level of coverage may be reduced through the introduction of co-payments.

[29] definition

(1) Exclusions of diseases and services to:

- Limit the financial cost of adverse selection that will not be addressed through membership exclusion on health status (for example HIV+ person are not excluded but HIV antiretroviral treatment are not covered);
- Limit the cost of the benefit package with the exclusion of non essential non-priority health services (e.g. exclusion of aesthetic surgeries);
- Limit moral hazard with the exclusion of health services that are prone to moral hazard (e.g. branded drugs);
- Avoid catastrophic risks financial consequences such as epidemics, medical consequences of wars that are difficult to cover without appropriate re-insurance mechanisms and generally should not be covered.

List of exclusions will vary according to existing ranges of services within the health system (consult annex n° for a detailed example of exclusions).

Selected exclusions should be weighed against the discrimination they might introduce against chronic ill potential and actual members and dependants. Specific measures can be undertaken to offset those consequences of exclusions such as linkages with appropriate public health programs to transfers insured patients to, once they have been diagnosed with one of the excluded diseases (consult annex n°_ for details).

Focus box
Exclusions

Regarding health services selection and financial accessibility, HMIS promoters may give a particular attention to the exclusion of:

Brand name drugs should not be covered, as they exist at lower price for equivalent quality (better controlled in some contexts) under generic forms. Only generic drugs should be reimbursed and should be made available. In some cases, some specific brand name drugs may be covered and reimbursed at the generic price. Ideally, drugs should be dispensed by definite and short-listed health facilities. Moreover only drugs under prescription should be reimbursed. The target population will generally put pressure on HMIS promoters to include brand name drugs in the benefit package. HMIS should resist to that demand to keep the HMIS affordable and keep cost under control. It will be most important in return to organise appropriate health education to explain the rationality of covering generic drugs only.

Dental care is most important but generally expensive and should be excluded in order to limit the premium level or when covered should be limited to basic filling, uncomplicated extraction and pain treatment.

Spectacle and artificial lenses should not be covered as they might render the benefit package too expensive and financially inaccessible while their payment can be prepared for without insurance mechanism.

HIV/AIDS retroviral treatment will be difficult to cover within HMIS but appropriate linkages should be built from the start of the scheme in order to orient patients diagnosed with HIV/AIDS to benefit from

appropriate care and treatment under specific program. However, it will be generally difficult to exclude the symptomatic treatment of opportunistic conditions that should remain within the benefit package.

Diseases that are already under national health programmes ensuring free access to treatment such as tuberculosis and leprosy in many developing countries.

(2) Co-payments (levels of coverage)

Providing free access to health care to insured members is generally the objective of HMIS promoters. However, a high level of coverage implies a high level of premiums. When the level of premiums exceeds target population's ability to pay, it will be necessary to reduce the level of coverage (for instance from 100% to 80%) in order to reach an acceptable level of premium without restricting the scope of coverage (range of services covered). The share of the cost of services that remains uncovered is called a co-payment.

Co-payments can take several forms as listed in the definition box n°_ .

Definition box

Possible types of co-payment

- ***Percentage co-payment***: only a percentage of the total cost is covered. For instance, if only 80 percent of the hospital costs are covered, and if hospitalisation costs total 100.000 Monetary Units, the scheme covers 80.000 MU, and the member has to pay the remaining 20.000 MU.
- ***Maximum benefit*** (***ceiling of benefits***) per time or within a given period. For instance, if consultation is covered up to 600 MU per consultation, and if the real cost of a consultation is 500 MU, the scheme covers the whole cost of the consultation and the member has nothing to pay. If the real cost of the consultation in 700 MU, the scheme covers up to 600 MU, and the member pays the remaining amount (700 – 600 = 100 MU).
- ***Monetary deductibles per time or per year:*** a fixed amount is born by the member. For instance, if the deductible is 1.000 MU per surgical intervention, and if the surgical intervention costs 5.000 MU the scheme will cover 4.000 MU and 1.000 MU is paid by the member. If it costs 1.000 MU or less, the total amount is born by the member.
- ***Deductibles in the number of use:*** a fixed number of times, cases, or days is born by the member. For instance, if the deductible is 1 day per hospitalisation, and the stay in hospital lasts 3 days, the scheme covers the 2nd and the 3rd days of hospitalisation while the member pays the first day.
- ***Limits on the number of reimbursements within a given period or per case of sickness*****.** For instance, if ante natal consultation is covered up to 3 consultations per pregnant woman and per year, and a patient uses only 2 consultations the scheme fully covers these 2 consultations; if the patient uses 4 consultations the scheme fully covers the first 3 ones, but the patient has to pay for the 4th one.

Levels of coverage (and co-payments) may be the same for all the insured persons (members and dependants, independently of their individual characteristics) or be different according to the age, sex, status (member or dependant), etc.

The introduction of co-payment presents two advantages:

- It contributes to decrease the level of the premium;
- It also contributes to reduce the risk of over-claiming: households tend to moderate their use of health services since a share of the health costs is out-of-pocket money.

However when the level of co-payment is too high, the scheme may not solve the financial difficulties of the members in case of illness. Ongoing debate actually exists related to the relevance of introducing co-payment to limit moral hazard in contexts where patients are already facing important direct non-medical costs (such as transportation cost, food and lodging for care takers during an hospitalisation) and indirect costs (as seen in part I.1.1.1) that already act as co-payment for low income households.

Besides introducing co-payment may increase transaction costs with health providers which will have to adapt their invoicing method for HMIS insured patients. Co-payments' management may also increase HMIS administrative burden compared (calculation and control of the co-payment).

When co-payment are set in order to limit the risk of over consumption, an alternative may be to consider appropriate health providers payment mechanism that can help containing health services' over uses without being forced to set co-payment that will deter frivolous use indeed but also useful contacts. In that respect, when possible, capitation payment mechanism (that will be defined in section II.2.3) should be favoured when covering minor risks.

Overall, the decision to set co-payment or not and, if any, under which form, will be strongly linked to the level of premium that has been evaluated as affordable. It will also depend on the relationship that have been set with health providers i.e. existing third party payment mechanism and providers payment methods as detailed further in section II.2.3

Differentiated benefit packages, periodicity of premium payment and sense of utility

Some services may appear to be a priority to the whole population, some others may be a priority to some groups and less important to some others. The scheme can therefore give members the choice between two or more packages of services: for instance, a basic package corresponding with main priority needs of coverage, and a more comprehensive package including services that are considered as priority by only a small set of the population.

When for some sub-groups of the target population (e.g., the ultra poor), the willingness and ability to pay are very low, it may be necessary to find alternative and/or supplementary sources of funding for these categories of persons (e.g. equity subsidies).

Affordability is also linked with the periodicity and methods of payment:

- The periodicity of payment of the premium needs to match households' periodicity of income. In rural areas, the most appropriate period for the payment of the premium is often after the harvest time (i.e. annual or biannual instalments). On the opposite, daily or weekly instalments may be appropriate for urban workers in the informal economy (e.g., street vendors).

- Affordability may also depend on the type of transaction that is acceptable as payment. Some households may have difficulty to pay in cash but may have little or no difficulty to pay in kind or by providing their labour[30].

Eventually and importantly, affordability is also linked to a sense of utility[31]. The perceived return for the premium can be as important as its absolute level. It is therefore important that:

- The administrative expenses (operating expenses) are as low as possible since they are often felt by the members as not fully justified[32];

- The scheme proves its ability to meet its obligations in all circumstances. It may therefore be difficult for a scheme to set from the outset high levels of premiums; and it is only after several months or years of efficient functioning (with health expenses being reimbursed on time in line with the benefits package(s)) that members may be willing to pay higher levels of contribution.

[30] Dror, D.M. and Jacquier, C.: 1999. *Micro-insurance: Extending health insurance to the excluded*. AISS; International Social Security Review, vol. 52, 1/99.

[31] Dror, D.M. and Jacquier, C.: 1999. *Micro-insurance: Extending health insurance to the excluded*. AISS; International Social Security Review, vol. 52, 1/99.

[32] For details on possible benchmarks, consult *Health micro-insurance schemes: monitoring and evaluation guide, ILO/STEP and CIDR, 2001*."The higher the proportion of premiums used for their primary purpose, namely payment of benefits, the greater the efficiency of the MHIS. A ratio around 75 per cent indicates an efficient scheme from this point of view".

Case study box – illustrating HMIS' diversity
Premium payment arrangements to increase affordability

In India, in ***Wimo SEWA***[33] members can choose whether an annual payment of premium (Rs.60) if the woman alone enters the scheme or Rs.75 if her husband is included, plus an annual administrative charge of Rs.5 or the fixed deposit arrangement. This later arrangement involves a deposit of Rs.500 if the woman alone joins the scheme and Rs.700 if her husband is included, plus a one-off administration charge of Rs.5. The fixed deposit can be paid at any time in the year and must be paid in cash into the member's account in SEWA bank where it remains. The annual interest ranging from 11 to 13 percent up to 1999 is used to pay the annual premium. The deposit is paid back to the woman when she reaches the age of 58.

In the Democratic Republic of Congo ***in Bwamanda*** health insurance scheme, insured members asked to set the premium payment period during the months that follow the second harvest period in March to April as the cash available after the first harvest was dedicated to pay school fees.

In the Philippines, ***in Novadeci Health Care Programme***[34], annual contribution is of Ph.P.600 (US$ 13). If payments for the year are less than the required Ph.P.600 (US$ 13), only a certain per cent of the benefit will be provided to the member. For instance, members that only manage to pay Ph.P.300 to Ph.P.499 are entitled to 50% of the benefits.

In Bangladesh, in ***BRAC MHIB***, all premiums are collected once a year as a lump sum. This type of payment may be a barrier to renewal or participation, and BRAC should research the possibility of a periodic payment method, at the village level, to increase participation and renewals[35]. However in the same scheme, a specific package "Equity package" is proposed to ease the access of the ultra poor.[36]

The selected coverage must enable the scheme to guard against health insurance risks

The coverage of basic health services (related to minor risks) utilized frequently by households, such as consultations, medicines, laboratory tests and injections, presents a high level of moral hazard i.e. "over-consumption" and "over-prescription", which can lead to a considerable increase in the scheme's expenses.

The coverage of costly and partially foreseeable treatments, such as planned hospitalisations, optical appliances and treatment for certain chronic illnesses, entails a high risk of "adverse selection" that can jeopardize the scheme's sustainability.

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[33] ILO/STEP: 2001. *Women organizing for social protection. The Self-employed Women's Association's Integrated Insurance Scheme, India.*

[34] ILO/STEP: 2001. *The Novadeci Health Care Programme*, Case study.

[35] Garand, Denis: 2004. *ILO-WEEH assessment of MHI, Grameen Kalyan and BRAC.*

[36] Préciser en quoi cela facilite l'accès des plus pauvres

The coverage of costly and unforeseeable health care services, such as unplanned hospitalisations, leaves the scheme highly exposed to "catastrophic risks". It may threaten the scheme with bankruptcy when the membership is small, which is often the case in the initial years of activities.

The scheme must therefore carefully select the services for which coverage is to be provided and introduce appropriate measures to ensure that health related risks will be controlled for (consult annex n°_ for a summary of measures that might be considered). More suitable mechanisms such as health savings, for covering foreseeable health expenses, or solidarity funds, for covering chronic health expenses may also be introduced.

Table n°: summary, is the coverage subject to insurance related risks?

	Hospital care (major risks)		**Basic health care (Minor risks)**
	Unplanned	Planned	
Is coverage subject to insurance-related risks?			
- Moral hazard and over-prescription	Yes	No	No
- Adverse selection and opportunistic behaviour	Yes	No	Partially
- Catastrophic risks	No	No	Yes

Source: Health micro-insurance schemes: Feasibility study guide, Volume 1: Procedures, Volume 2: Tools, ILO/STEP, 2005.

Case study box – illustrating HMIS' diversity
Health benefit- premium formula (à développer)
[…]
One package and family size premium CBHI
Several packages and different premium payment possibilities
Yeshawini – single product and single premium and need to review premium

II.2.3 Which conditions to access health services covered?

When designing health micro-insurance product, promoters have to clearly define the different conditions that, beyond membership criteria, will rule the access to the benefit package in order to ensure the most efficient use of it.

Defining conditions to access the benefit package essentially questions the conditions to access health services covered and therefore inevitably raises organisational issues related to health services provision (organisational issues will be detailed in section II.3).

Some options and challenges that HMIS promoters may face when defining conditions to access health services covered , are listed in the box below.

Checklist box n°_
Conditions to access health services_ options and challenges:

Health benefit provision:
- ❑ Through a selected range of health providers or any providers that insured may choose

Financial conditions to access health services at the time of illness:
- ❑ Payment of heath care services at the time of illness and reimbursement (full or partial) upon invoice
- ❑ Free access or payment of a co-payment (Third party payment arrangement with co-payment)

Other conditions to access health services covered (rationing mechanisms):
- ❑ Waiting period
- ❑ Prior agreement requested or not
- ❑ Mandatory referral or not
- ❑ Standardised therapeutic protocols or not

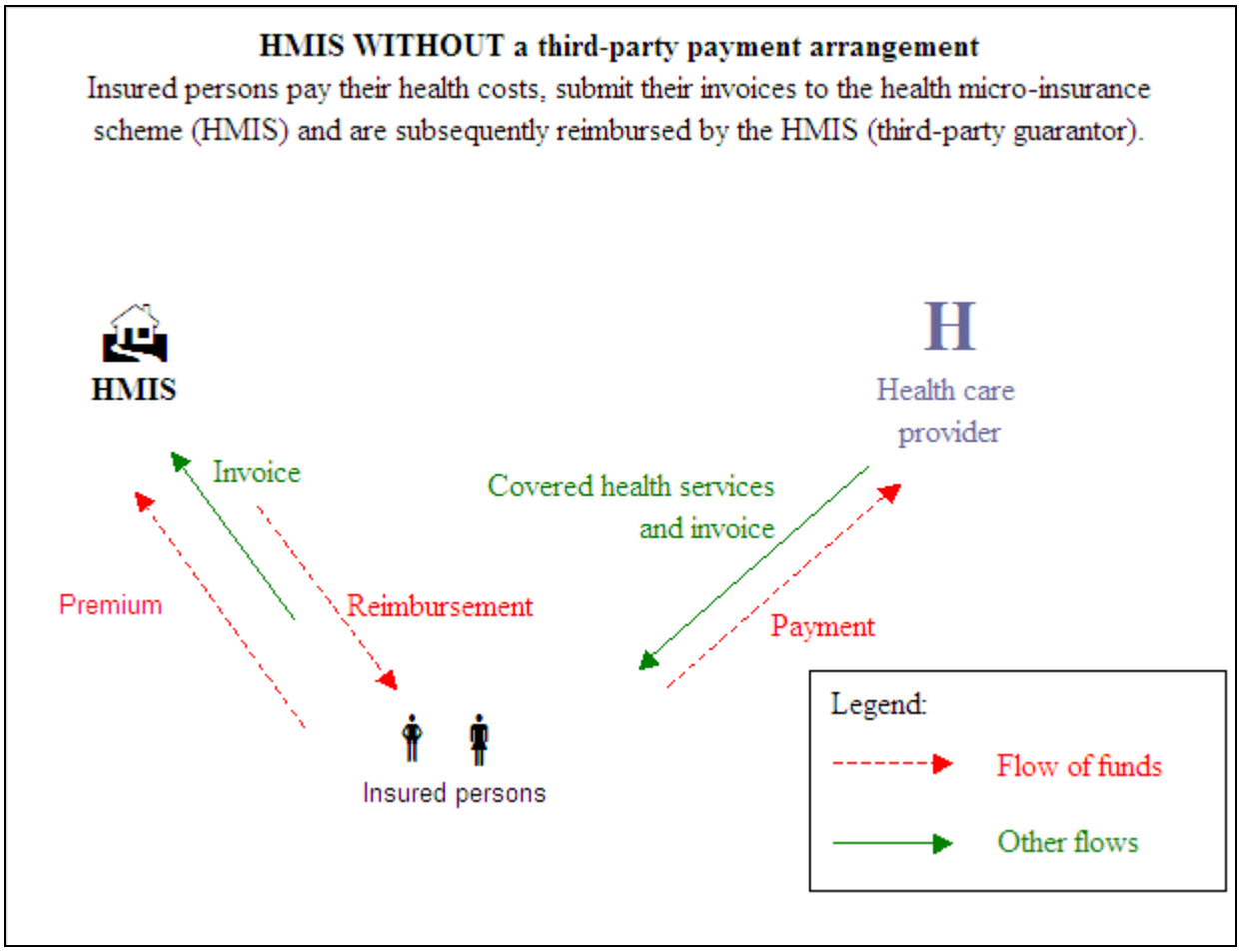
When setting rules to access health services covered, main challenges for promoters may be as follows:
- ❑ Ensure the most efficient use of the benefit package
- ❑ Actually remove financial barriers to access health services through appropriate third-party payment mechanism and therefore through appropriate contractual arrangement with health providers
- ❑ Limit administrative formalities to ease access for insured while limiting management costs and matching with limited managerial capacity.

Health benefit provision and financial access to health services covered

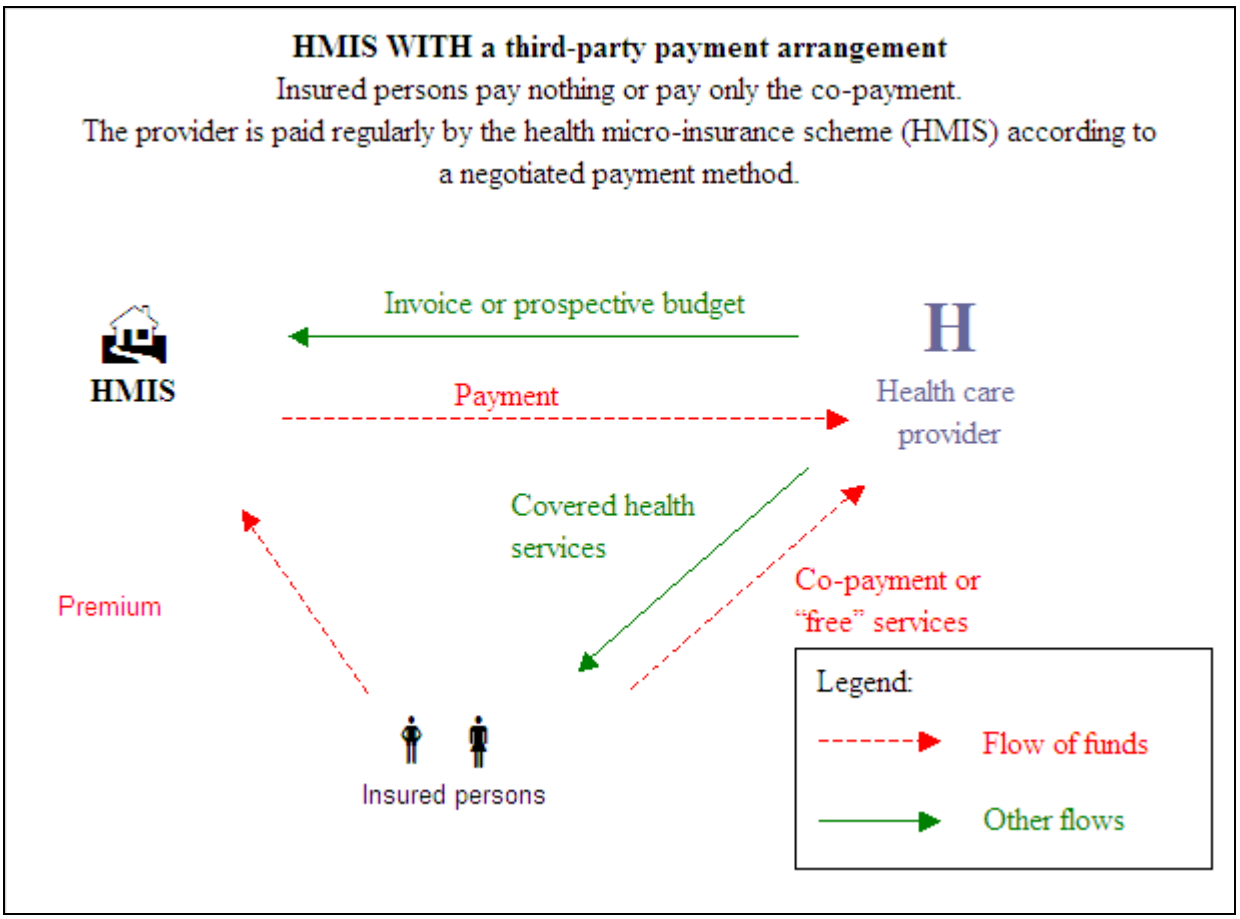
When HMIS and health providers are separate entities, one important issue for HMIS promoters will be to define whether insured members can access health insurance benefit only in selected health care facilities or if they are free to choose the health facility where they wish to receive health care.

Some health micro-insurance schemes cover health care services provided by any health care facility, either public or private. In those schemes, as depicted in the graph below, insured

persons pay their health costs, submit their invoices to the HMIS and are subsequently reimbursed (fully or partially depending on the adopted health insurance benefit formula) by the HMIS.



Some other schemes only cover the services that are provided by a limited number of health care facilities, generally chosen on criteria of proximity (they need to be close to the target population), quality and cost of the services provided.



HMIS that short-list health providers usually aim to negotiate contractual arrangement regarding:

- quality of health care services delivered;
- tariffs charged;
- method of payment for services used by insured members (see details further page_).

Setting appropriate contractual arrangement with health providers is a critical stake for the viability of the scheme since it can highly increase its efficiency and attractiveness by:

- reducing the cost of coverage (since the scheme manages to control the quantity delivered and the prices charged);
- granting a minimum level of quality of care (through agreement on therapeutic protocols as well as welcoming conditions for insured patients);
- actually removing financial barriers to access health services (with third-party payment agreement insured members only have to pay a co-payment - or nothing - to access health care and do not need to resort to credit or other coping mechanism to find needed money to access health service and then be reimbursed by the HMIS).

Health providers' payment methods adopted by the HMIS will notably be of critical importance regarding the scheme's viability and efficiency since each payment method will give different

incentives for providers to control the cost and the quality of the services provided to insured (as detailed in the following §). Negotiating appropriate contractual arrangement with health providers regarding method of payment will be a critical and rather difficult task for HMIS promoters in the setting up process as it will be underlined in part III.

Health providers' payment within a Third-Party Payment contractual arrangement[37]

There are different ways of paying contracted health care providers for the services they provide to insured. Four methods may be distinguished:

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

- Payment by ***cluster of health services*** consists of paying health care providers a global fee for a group of related health services.

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

- A ***capitation payment*** consists of paying the health care provider a global fee per person covered — per "head"— and for a defined period, usually one year. The payment is disconnected from actual use of health services by insured and is made prospectively (in advance to health provider).

Each method of payment has its advantages and disadvantages in terms of countering moral hazard and the risk of over-prescription, on the one hand, and in terms of the quality of health services, on the other (as detailed in table n°_ below).

Global payment mechanisms — based on clustered health services, episodes of illness or capitation — are techniques that permit shifting to health care providers part of the financial burden of the risks related to sickness. When a patient consumes little, the provider "wins". When a patient consumes more than average, the provider "loses". This is referred to as the transfer of risk from the health micro-insurance scheme to the health care provider. These mechanisms limit over-prescription to the extent that any increase in prescriptions (medicines, diagnostic interventions, etc.) is borne by the provider when these services are included in the global fee.

Conversely, in the case of a fee-for-service arrangement, health providers may have a tendency to prescribe more medicines than necessary, require patients to return for consultation several times, or perform a greater number of diagnostic tests than necessary in order to amortize their medical equipment, etc. Moreover, such tasks as claims management, checking invoices and paying

[37] Philippe, Valérie : Partie présente dans le draft de Valérie mais reprise sous sa forme améliorée dans le guide de faisabilité : est ce un problème ?

providers, are relatively simple under the global payment method. Conversely, under the fee-for-service method, these tasks may require the services of one or more specialists.

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

Lastly, the capitation method of payment may give rise to a form of risk selection⁂ on the part of providers. In offering services, providers may tend to favour patients who present a low risk of illness and who will therefore not consume too many health services, and to discourage those who present a high risk. Providers paid under capitation systems may for example excessive referral of complicated cases to an upper level health facility.

Table n°_: Summary of advantages, disadvantages of different providers payment methods and accompanying measures

Method of payment	**Advantages**	**Disadvantages**	**Accompanying measures**
Fee-for-service	Contributes to quality health care	Exposes scheme to risk of over-consumption and over-prescription Complicates management Requires that health micro-insurance schemes bear entire burden of risk	Checking of invoices Prior agreement Co-payments
Global payment (clustered health services, episode of illness, capitation)	Reduces risk of over-consumption and over-prescription Simplifies management Allows the transfer of risks to health care provider	May lead to reduction in quality of health care May encourage risk selection	Quality control of health care through regular inspections Monitor attitudes of health care staff (risk selection)
- Clustered health services		*May encourage misclassification of health services clusters towards expensive ones* *May encourage providers to contacts for a given episode of illness*	
- Episode of illness		*May encourage early discharge of patient in case of hospitalisation*	
- Capitation	*Allows to the entire transfer of financial risks to health care provider*	*May encourage excessive referral for expensive cases*	

Rationing mechanisms : waiting periods, mandatory referral, therapeutic protocol and prior agreement

Beyond the possibility to arrange third-party payment with health providers, HMIS will have to put in place additional rationing mechanisms to ensure the most efficient use of the benefit package. Waiting periods, mandatory referrals, therapeutic protocols and prior agreement are useful (necessary) measures to be put in place.

A ***waiting period*** is the time following enrolment during which members pay their premiums but cannot yet benefit, or enable their dependents to benefit, from the services provided by the health micro-insurance scheme. Waiting periods are important and should be set to:

- Prevent opportunistic behaviour in persons who might enrol in the scheme at a particular moment of need – in anticipation of childbirth or a planned surgical operation, for example – and withdraw from the scheme once the need had been met. This is particularly important when deliveries and planned hospitalisations are covered.
- Contributes to reduce the cost of the coverage during the first year of affiliation, which can allow reducing the level of premium or alternatively be used to build up financial reserves.

There are no standard waiting periods. They can vary from one covered health service to another. If a waiting period is too short, it may fail to prevent opportunism and adverse selection; if it is too long, it may discourage enrolment. In the case of maternity, the usual waiting period is from nine to ten months. For other risks, this period is usually shorter – generally lasting from one to three months. Setting waiting period may be less useful when membership is automatic for a pre-existing group.

The challenge for HMIS promoters will be to set appropriate waiting periods while keeping the system simple to manage. Eligibility would be difficult to control if every single health service covered has a different waiting period. It would also be difficult to explain to insured members and may create damageable deception if not understood correctly by insured persons.

Introducing a procedure ***of mandatory referral*** can prevent unnecessary use of specialised and expensive treatments. Secondary and tertiary health care services (e.g., hospitalisations, specialized care) are covered provided that the patients have been first referred from a basic health care provider (e.g., non specialised doctors or first line health facilities the health system).

Agreeing with health providers on the use of ***standard therapeutic protocols*** can highly contribute to control costs and quality of care. As standardized treatment procedures, a therapeutic protocol defines, by type of pathology, the diagnostic procedures (laboratory, radiology or other), medical care, and drugs to be prescribed. If they are followed, they allow the

patient to be treated cost effectively.

A procedure of prior agreement can be set up specifically for some expensive treatments (e.g., eye glasses, predetermined hospitalisation) and can reduce the risk of over-claiming and over-prescription. The patient needs to forward to the scheme an estimate of the health care expenses before using the health services. The scheme will only cover the expenses it has previously agreed on.

Procedures of prior agreement and referrals are not appropriate in case of emergencies and are generally relaxed in such situations.

Verification of eligibility to access health services covered

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

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

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

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

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

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

Overall, prior agreement, verification following the delivery of health care, or quality controls require mobilising the expertise of a medical adviser.

Case study box – illustrating HMIS' diversity
Conditions to access health services covered (à développer)
[…]
Bwamanda (direct provision of health care)
SEWA (no third party payment and improvement to provide cash benefit as soon as possible)
ORT Plus (capitation and mandatory referral)
Laos CBHI (referral and essential benefit package and standard protocol)

II.3 Setting-up a HMIS, organisational and operational challenges

Setting-up a HMIS will require designing the most efficient internal and external linkages to ensure that core insurance functions and key management tasks are properly assigned and handled to allow the scheme delivering health insurance services to the target population in a viable and efficient manner.

II.3.1 Key questions to approach HMIS' organisational framework

In simple terms, setting-up a HMIS organisational framework first requires clarifying who will be responsible for what, as well as who will do what, and then requires ensuring that all functions can be handled properly in an efficient and sustainable way given the resources of the scheme.

Checklist box n°_
key questions and challenges regarding HMIS' organisational framework

Who will do what?
Structural and governance issues
- ❑ Who bears the insurance financial risk?
- ❑ Who provides health services covered?
- ❑ Who is (financially) responsible in front of insured people?
- ❑ Who is (financially) responsible in front of health providers?

And more generally, who handles
- ❑ HMIS decision making functions?
- ❑ HMIS executive functions?
- ❑ HMIS supervisory functions?

Core insurance functions
- ❑ Who designs and prices the product?
- ❑ Who markets, communicates and sales the product?
- ❑ Who enrols and collects premium?
- ❑ Who handles the claims?

Standard management functions
- ❑ Who handles the accounting and financial management?
- ❑ Who monitors and evaluate operations?
- ❑ Who audits and controls procedures?
- ❑ Who manages and trains human resources?
- ❑ Who negotiates the contracts for outsourced services?
- ❑ Who pays health providers (when applicable with Third-party payment agreement)?

Challenges
Clear governance structure and legal status to avoid corruption
Appropriate skills for a professional management with internal capacity building process and outsourcing
Limited management costs to limit premium level

Appropriate involvement of the target population to ensure health benefits' responsiveness, limited fraud and high enrolment
Adapted (decentralised) distribution and communication methods that actually reach the target population

The answers to those questions will shape the organisational structure and the governance of the HMIS. Once again there is no unique model but contextual answers. The distribution of functions and responsibilities will depend on various criteria such as:

- objectives and mission of the scheme as envisioned by the promoting organisation (if the promoting organisation value as a fundamental value the involvement or not of the target population in the management);
- other activities of the promoting organisations if any (credit and savings services; health promotion; health care provision; life, car insurance services, etc.)
- internal competencies of the promoting organisation compared to overall required skills;
- existing possibilities to outsource efficiently specific functions (such as enrolment, premium collection; accounting; health care provision; etc.);
- size and geographic distribution of the target population;
- etc.

Overall, decisions regarding health care provision, insurance functions, insured population's involvement in the management as well as decision regarding the legal status are generally the ones that will shape the organisational structure of the scheme.

II.3.2 Which capacities for a sustainable HMIS?

As synthesized in *Health micro-insurance schemes: monitoring and evaluation guide (ILO/STEP and CIDR, 2001)* and in reference to major insurance functions and core management tasks defined earlier in section II.1, a sustainable HMIS should gather and master the following tasks or capacities:

CAPACITY	DESCRIPTION
(1) Distribution and Marketing	- Description of benefits and how to claim, renewal and other provisions are clearly communicated to members. - Clear messages are used to motivate participation. - Constant refreshing of approach. - Target set for participation in the MHIS. - Renewal ratio monitored.
(2) Membership monitoring and management	- Database developed, includes membership and their dependents, coverage history, premiums history, and claims history of each member. Claims history includes claims causes coded in International Claims Diagnostics Code format, breakdown of charges by benefit category, transaction details. - Reports include claims, premiums, membership status, etc. split by a variety of parameters. - Analysis of results focused on understanding how to reach sustainability.
(3) Premium collection	- Efficient collection of premium, in form that will enhance participation.
(4) Claims processing and health care providers	- The Management Information System (MIS) is able to produce reports that will enable detection of developing trends in the claims experience. - Prevention and health education priorities by emerging diseases treated. - Treatment protocols are developed, followed and reviewed to maintain cost effectiveness. - Periodic audits of service providers to ensure meeting expectations. - Surveys conducted with members to measure client satisfaction.
(5) Management procedures	- Sets plans, focused on improving results, uses this Guide or similar tools to actively monitor progress. - Produces and adheres to operational plans and budgets which in turn are based on the HMIS five year - business plan. - Human Resource, Training, Investment and service policies are followed. - Internal and external audits are conducted regularly as well as periodic actuarial reviews.
(6) Quality of Risk Portfolio	- Results are studied using claims experience extracted from the MHIS and/ or industry databases. - Information used to provide guidance for management decisions. - Member satisfaction is measured, to assist in revising benefits.
(7) Financial Statements	Ability to produce, for a given time period, measuring all cost: - Income statement. - Balance sheet. - Cash flow statement.
(8) Cash flow monitoring and investments	- There is a strict adherence to an Investment Policy. - There is constant monitoring of the investment portfolio to make sure that the maturities and investment income matches the company's liability outflows. This requires that cash flows are projected and the portfolio reshuffled in order to match liabilities. - Investments will be diversified.

Source: *from Health micro-insurance schemes: monitoring and evaluation guide (ILO/STEP and CIDR, 2001).*

The proper performance of the tasks involved in the operation of the insurance is a critical factor in the viability and sustainability of the HMIS. This performance partly depends on the way responsibilities are organized and distributed and partly on the skills of the people who perform those tasks[38].

II.3.3 Governance structure and legal status

II.3.3.1 Internal bodies and actors[39]

Governance structure

As for any enterprise, HMIS promoters will have to draw the scheme's architecture around the following standard organisational structures:

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

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

Actors

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

- ***Scheme members***. In mutual organizations, the power to make decisions is entrusted to members with a seat in the general assembly;
- ***Volunteer, compensated or salaried staff*** by the health micro-insurance scheme or by

[38] *Health micro-insurance schemes: monitoring and evaluation guide (ILO/STEP and CIDR, 2001).*

[39] Partie reprise du draft de Valérie mais version anglaise améliorée dans le guide de faisabilité.

other branches of activity of the responsible organization (pooling of human resources). The scheme's ordinary activities, such as the collection of premiums, enrolment of new members, etc. are often carried out by volunteers during the start-up of the scheme. Once it has been in operation for several years, a scheme is usually able to compensate these persons or to hire salaried employees. When the operating costs of a scheme are subsidized, the scheme may envisage hiring salaried employees from the start. However, its viability could be undermined should this type of assistance no longer become available;

- ***Partner health care providers*** who may perform certain managerial tasks, such as collecting premiums, enrolling new members, checking the membership cards of insured persons;
- ***Technical assistance*** provided by projects, NGOs, decentralized departments of the State, trade unions or associations, technical unions, etc.;
- ***Specialized consultants***, such as accounting experts, statisticians, etc.

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

II.3.3.2 Legal status

When setting up a HMIS, promoters will have to ensure that the HMIS operates under an appropriate legal status. Adopting a legal formula is necessary in order to establish and formalise contractual arrangements with third parties such health providers or re-insurers. When legally recognized, HMIS is subject to control by the regulatory authorities, which are a safeguard for members and third parties.

Health micro-insurance schemes may take the form of a variety of legal entities, depending upon their objectives – whether more social or more commercial in nature – and the legislative environment in which they operate. There are two possible situations.

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

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

Experience so far shows an overall legal vacuum concerning HMIS regulation. Most of HMIS are operating outside commercial insurance law (that is generally not appropriate as financially too constraining) and use associative, cooperative status or mutual status (*Mutuelle d'Assurance Santé* in many Western African countries) to provide health insurance services. Some countries

have started regulating health micro insurance such as in India, Indonesia, Senegal[40]. Predominant status commonly used by HMIS varies from one country to another and the so called "cooperative status" may differ in its requirements from one country to another. In the Philippines Multi Purpose Cooperative status for ORT Plus scheme and cooperative status for Novadeci; in India association status for Wimo SEWA and Ashwini, Trust for Yeshavini; in Nepal cooperative status for Gefont, non profit association for Lalitpur.

As mentioned earlier, the choice of the legal formula will impact on the governance structure of the scheme as it usually defines the governance structure (decision making, executive and supervisory bodies) and may also precise the functions that the HMIS can handle and functions that can be delegated.

II.3.4 Internal and external linkages

II.3.4.1 Internal linkages (defining the relationship of the scheme to the other activities of the responsible organisation)[41]

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

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

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

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

- ***Legal.*** When the responsible organization is a health care provider, it is generally desirable for the health micro-insurance scheme to have an independent legal status, separate from that of the health facility;
- ***Accounting and financial.*** Even if the scheme has an independent status, transfers of funds may be envisaged between the other activities of the responsible organization, on

[40] Faire référence au travail de STEP sur le cadre légal pour la micro assurance santé en Afrique de l'ouest ?

[41] Partie reprise du draft de Valérie mais avec version anglaise améliorée du guide de faisabilité.

the one hand, and the health micro-insurance scheme, on the other. Hence, the scheme's operations may be financed in part from the earnings generated by economic activities. Transfers from one activity to another must remain transparent, which implies separate accounting;

- ***Functional.*** It is important to decide if the future scheme will be assisted by decision-making and supervisory bodies that are separate from those of the original responsible organization, or if certain bodies will be common to both. It must also be decided what resources (human, material, physical facilities) may be made available to the new scheme in an effort to limit its operating costs in the first few years.

II.3.4.2 External linkages

Functional linkages

As already mentioned, some functions may be outsourced to external organisations to facilitate the management such as health care providers for health care provision, insurance company to handle insurance functions and risks, re-insurance company for re-insurance (when applicable since only HMIS with an appropriate status may be eligible for reinsurance), chartered accountant for accounting, medical advisor for quality of health care audit for example.

Such functional linkages will be determinant for the viability and efficiency of the scheme. Smooth and cost effective relationships will have to be set-up through an appropriate selection of partners and formalised and enforced contractual arrangements (see part III section regarding negotiation with health care providers).

Technical and financial supportive linkages

Health micro-insurance schemes may and usually benefit from the support (technical / financial) of donor agencies, NGOs, supporting structures, private consultants, etc.

Linkages to reach the poorest and/or channel social benefits

HMIS may also develop linkages with:

- statutory social insurance schemes. Those linkages may be financial (e.g. subsidies of eligible members' premiums) or functional, with health micro-insurance schemes delivering subsidized non-contributory social insurance coverage to the very poor.

- social assistance institutions and specific health programs, linkages may consist of channelling social services to eligible members.

Technical coordination structures and advocacy networks

As many mutual organisations in West Africa, small scale HMIS may form regional or national associations (coordination structures) in order to:

- develop stronger negotiating power towards the government as well as public and private health care providers,
- share knowledge and increased access to technical training,
- share technical functions (e.g., accounting and financial management) and manpower,
- benefit from greater financial security through mechanisms such as re-insurance, co-insurance, or the set up of a guarantee fund.

HMIS may also create or participate in networks and/or consultative committee with other critical stakeholders for their development such as the State, civil society organizations, donor agencies, technical support organisations (see focus box n°_ presenting "the coordination network"). In joining such networks HMIS generally aim to exchange views and experiences with other operators (through meetings, publications, web sites), to increase their access to information, knowledge and technical training, approach supporting structures and actively contribute to national negotiations with the State on major issues such as the legislative framework adaptation to HMIS characteristics, the definition of a legal status, the set up of financial mechanisms to secure HMIS, etc.

Focus box
Advocacy network for HMIS in Africa _ The "coordination network" (La Concertation)
(à améliorer)

Since 1999 a number of support organisations and international programs as well as many administrators and health micro-insurance schemes have gathered in «La Concertation entre les acteurs du développement des mutuelles de santé en Afrique de l'Ouest et du Centre».

The "Coordination Network" provides a broad variety of services: a Website, a newsletter, a monitoring system for mutual health organizations and thematic workshops to support the mutual health organization movement.

The "Coordination Network" receives technical and financial support from other international partners besides STEP, USAID and its PHRplus program, GTZ and its health insurance project, AIM, ANMC, WSM, RAMUS, UNMS and MFP.

A similar network will be operational in Asia in 2005.

Overall, no standard model exist to guide HMIS potential promoters to find appropriate internal and external linkages to ensure an efficient management of the scheme. Examples of organisational set-up are given in the case study n° to illustrate HMIS organisational diversity.

The challenge for HMIS promoters will be to ensure a professional management while limiting management costs of the scheme and keeping the scheme responsive to its target population's needs through an appropriate degree (level) of community participation.

For small scale schemes, the challenge will be difficult considering their limited premium resources. For such scheme, it is often not possible to recruit qualified staff for each of the functions required for the proper operation of the HMIS. A HMIS manager may often be responsible for several functions, even if they require different skills (finance, relations with insurer and providers, technical monitoring of risk portfolio, etc.). In that regard, HMIS relying only on voluntary staff have shown their limitations in ensuring appropriate pricing and overall management of insurance functions. Gathering and keeping qualified staff is a major difficulties for HMIS and especially for mutual organization and the shortage of adequate skills is one of the major causes of HMIS failure indeed (add data for evidence). As mentioned regarding external linkages, joining a technical coordination structure to share expertise may be a cost effective solution for some HMIS.

Case study box n°_, illustrating HMIS diversity
Organisational set-up (to be developed + add organisational diagram in annex SEWA /Yeshawini /ORT Plus)

Major generic organisational models following who handles/manages the insurance and health provision functions + outsourcing of other functions

- Type 1/ the classical design: the voluntary organization plays the role as an agent, purchasing care from providers and insurance from insurance companies.
- Type 2/ the HMO design (Health Maintenance Organization): the health provider plays the dual role of providing health care and running the insurance program.
- Type 3/ the mutual design: the voluntary organization is the insurer, while purchasing care from independent providers.
- Types1/2/3 with a possibility of outsourcing of specific functions (accounting, medical adviser, etc.)

Models regarding the insurance function

- The scheme provides the insurance as an own activity and has a linkage with an external company as re-insurer such as in Yasiru. (à verifier)
- An external organisation is linked to the scheme and is responsible for managing the insurance activity such as in Ashwini.

Models regarding technical management

- The scheme does everything itself such as in PHECT with the Local Coordination Committee handling all managerial functions.
- The parent company does everything itself such as in Assef.
- An external organisation takes care of the different functions such as in Novadeci: Daily operations and transactions are handled by the clinic staff, the medical service department head and

the general manager. The work involves attending to the medial and health care needs of the members, monitoring contribution collections, benefit disbursements and other income and expenses of the programme by preparing monthly and annual reports and advising the Board of Directors on policy matters pertaining to the scheme.

- Functions are being spread over different actors such as in Yeshasvini: the cooperative trust is responsible for decision-making, control, marketing and design, insurance, financial management; the government of Karnataka provides subsidies; the Karnataka State cooperative department is responsible for information and communication; the TPA is involved in the management of claims and accreditation of health care providers; the cooperative banks collect the premiums, while the cooperative societies enrol the members.

Models of decision-making

- The scheme is integrated in the decision-making process of the parent company. The parent company has the sole power over the scheme such as for SEWA as Assef. Insurance Committee in the SEWA General Assembly has the decision power. The members of the scheme are represented in the Insurance Committee through union and village leaders. In Assef,
- Different actors are involved in the decision-taking process of the scheme such as for Ashwini: the scheme has the power of decision-making together with the parent company Accord. Also, the scheme tries to be as open and participative as possible concerning decision-making, therefore everyone can participate in this process.

II.3.5 Which management tools and documents ?

A minimum set of tools has to be designed and properly used for the setting up of the scheme and its daily management.

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

Management tools and documents are to be prepared on the basis of the established operating rules. Management procedures must be defined for the following operations: enrolment, changes in membership, withdrawal, collection of membership fees, premium allocation, requests for prior agreement, reimbursement of insured persons in the absence of a third-party payer and payment of providers under a third-party payment mechanism. Each operation has its rules for recording data, checks to be performed (e.g. before settling claims, the insured person's entitlement to benefit must be checked) and rules for issuing documents or payment orders. Rules that must be followed for monitoring membership, premiums and claims have also to be clarified. the checks that are to be performed, the indicators to calculate, the measures to be taken to deal with discrepancies and the frequency of checks and calculations have to be clearly set.

As thoroughly explained and underlined in *Health micro-insurance schemes: monitoring and evaluation guide (ILO/STEP and CIDR, 2001),* HMIS managers must constantly appraise their activities and have available the information they need to take decisions. In that regard, they need an appropriate monitoring system, consisting of a series of tools and procedures, otherwise called Management information systems (MIS).

Checklist
HMIS major reference documents and management tools

Reference documents

- ❑ Action plan
- ❑ Official status documents according to the legal formula
- ❑ Organizational chart
- ❑ Management procedures manual
- ❑ Contracts with partners: health provider(s), regulated insurer(s), local association(s), health program(s)

Essential tools

- ❑ Insurance management tools and documents :
  - Tools pertaining to membership management
  - Tools pertaining to premium management
  - Tools pertaining to claims management
- ❑ Accounting and Financial management tools
- ❑ Promotion tools
- ❑ Insured's satisfaction assessment tools

Management Information System (paper-based; computer- based or mix)

II.3.5.1 Reference documents

The action plan (business plan)

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

The statutes and the organizational chart

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

The statutes fulfil several roles:

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

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

The internal rules or the insurance contract

The internal rules (for mutual organization)

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

The internal rules complement the statutes. They clarify a certain number of the mutual organization's methods of operation. The internal rules constitute a reference document that serves to establish the responsibilities of the members and the internal bodies, and to ensure the proper management and supervision of operations.

The insurance contract

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

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

The procedures manual

The procedures manual is a document that describes, for each management operation, the activities to be performed, the tasks of the actors involved and the management tools and documents to be used. It may also describe the rules to be followed for monitoring membership, premiums and claims.

The procedures manual fulfils several functions:

- it serves as a reference, helping to prevent omissions;
- it encourages actors to become familiar with each others' tasks; and
- it constitutes a basic document for training the new managers and staff of health micro-insurance schemes.

Contracts with health providers

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

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

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

Bibliographic references to consult samples of the reference documents mentioned are given in annex n°.

II.3.5.2 Essential management tools

Management tools and documents (enrolment, premium collection, claims)[42]

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

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

Tools and documents pertaining to claims management should make it possible to avoid the occurrence of certain insurance-related risks, such as fraud, over-consumption of health care, etc. However, they must not be so numerous or so complicated as to cause members to experience undue delays in obtaining care. The tools and documents utilized differ depending upon whether the scheme sets up a third-party payment mechanism or a mechanism to reimburse members following the delivery of health services.

In a manual or paper-based management system, tools and documents consist in sheets, registers, cards, etc. Examples of tools for manually and computerised management for different operations of the management process are given in annex n°_.

[42] Partie reprise du draft de Valérie avec version anglaise améliorée dans guide de faisabilité

Accounting documents: initial balance sheet, journal and general ledger

The initial balance sheet describes the initial financial situation. The opening or initial balance sheet contains an inventory of assets, funds and accounts payable of the health micro insurance (it is a table with two columns, with on one side the assets and on the other side the liabilities).

The journal is a book that registers all the accounting operations, whatever their nature is, in a chronological order from day to day. The entries in the journals are regularly posted in the general ledger.

The general ledger is a document that regroups the whole of the accounts of the health micro insurance scheme. It can be a card tray or a file with sheets, each sheet corresponding to an account.

Financial management and monitoring tools

On top of the budget estimation, HMIS managers will have to make a cash flow plan. It includes a forecasted table of cash revenues and expenses in a given period (several months or a year). The cash flow plan envisions the amounts and dates of revenues and expenses that need to be taken into account that period. This allows foreseeing the liquid assets needed in order to face its immediate commitments, and avoiding keeping reserves in too large quantities, the funds in surplus can be invested so that they produce interests and improve the result of the accounting period.

The financial follow-up consists of monitoring the budget and the cash flow. Both cases imply comparing the estimations that were made with the performance during the accounting period. This comparison can be done using monitoring sheets that include for each line of the budget and the cash flow the forecast, the performance and the variance between the forecast and the performance expressed in absolute value (monetary units) and in percentage.

Promotion tools

Promotion tools are documents that are used by the promoters of the scheme (e.g. facilitators) to present the health micro insurance scheme and the benefits and services proposed to the target population. Promotion tools must be design to comply with the marketing and communication strategy of the scheme. Since HMIS rely on voluntary enrolment, promotion tools are of critical importance to encourage membership and promoters will have to invest sufficiently in promotion tools to provide attractive leaflets that are easy to understand for the target population.

Two types of tools can be distinguished: those used by the promoters to provide a clear presentation of the scheme and answer to remarks of the target population (e.g. list of arguments and counter-arguments) and those viewed or read by the prospects (e.g. information brochures or panels).

Besides paper based promotion tools, other promotions techniques such as theatre play, songs, village meeting with beneficiaries telling how they benefited from the scheme, etc.

Insured satisfaction assessment tools

HMIS promoters may (should) design and use simple questionnaire survey to assess on a regular basis:

- Insured patients' satisfaction regarding health insurance benefits;
- Insured patients ' satisfaction regarding quality of care and services;
- Former insured reason for dropping out;
- Non-insured person reason for not joining the scheme;
- Insured patients perceived impact of HMIS.

II.3.5.3 Management Information System (MIS) for accurate monitoring

As thoroughly explained and underlined in *Health micro-insurance schemes: monitoring and evaluation guide (ILO/STEP and CIDR, 2001),* HMIS managers must constantly appraise their activities and have available the information they need to take decisions. In that regard, they need an appropriate monitoring system, consisting of a series of tools and procedures, otherwise called Management information systems (MIS).

The setting up of HMIS inevitably requires the development and the use of a Management Information System (MIS) that will allow collecting appropriate data and follow relevant indicators to check if the HMIS is on track to reach its objective.

It can be developed under a very simplistic form and be paper-based at the launch of the scheme and during a pilot phase that serves to test the procedures when enrolments and overall operations are limited in volume. Once the procedures are adjusted and validated, the development of a computerised information system will be a critical step to prepare and accompany the growth of the scheme.

Case study box
Information system articulation in the Community Based Health Insurance pilot project in Lao PDR

Three sub-databases (registers) compose the information system:

- The **Registration database**: "identification of members of the scheme"
- The **Contribution database**: "who paid when, and what is their status now?"
- The **Admission/Transfer/Discharge (ATD) information system**: "how much health care did the insured members receive?"

A simple **accounting** system, balancing the funds from contributions coming in, with the expenditures on running costs and the capitation payments to the hospital(s) is linked with the contribution database.

Each of the databases is associated with a number of forms and receipts, to collect the information in the community and on utilization of health services in the hospital.

At this early stage of the CBHI development, the information system has been intentionally kept on a paper-based format at district management teams who provide data to the central management team who is equipped with a computer and generate monthly report.

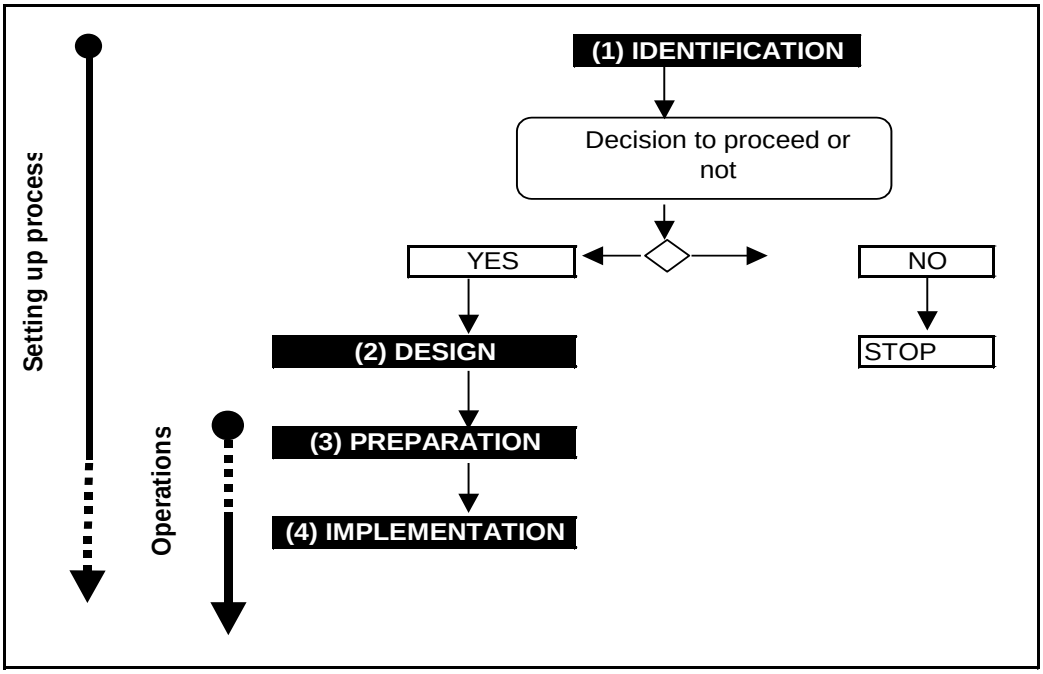
Source: Community based health insurance Lao PDR, review of CBHI pilot scheme project MOH and WHO, Dr Aviva Ron, 2004

The challenge will be to develop a tailored-made computerised system that is simple to handle and that is not too expensive to develop and maintain. Experience has been gained from other fields such as microfinance and specific programs already exist such as "*MAS gestion*" and "*MAS pilot*" designed and developed by STEP (see focus box n°_ in part III).

Part III Setting-up a Health Micro Insurance Scheme, process

Unsurprisingly, experiences and existing literature reviewed show that setting-up a Health Micro Insurance Scheme is always a unique process. HMIS setting-up process will be essentially shaped by the general context in which the scheme is to operate (target population, social and cultural background, health system characteristics, legal requirements, institutional support) and by the nature, objective and resources of the promoting organisation (community organisation, health providers, workers association, micro finance institution, etc.).

However, as for any project, four critical phases may be distinguished (and followed) in the setting-up process of a HMIS: (1) Identification; (2) Design; (3) Preparation; (4) Implementation.



Beyond those standard phases, all experiences without exception show that setting up a HMIS is an iterative process involving adjustments after the initial design of the scheme and the launch of the activities. This iterative character underlines in one hand the still nascent stage at which the health micro insurance sector is actually in many countries and therefore the learning by doing process and, on the other hand, the critical importance of the monitoring function and the need for a pilot testing phase under certain conditions.

Overall, setting up a HMIS represents a significant investment in time, money and human resources that should be acknowledged and planned for, at the onset of the scheme.

This section will not give detailed guidance on how to set up a HMIS but aims to provide potential promoters with an overview of the possible logical phases and the major tasks that may be undertaken when setting up a HMIS.

As reminded below, specific guides in the same ILO/STEP collection should be consulted to go in details into methodological aspects, tools and practical examples regarding feasibility study, management and evaluation for HMIS

- Health micro-insurance schemes: Feasibility study guide, Volume 1: Procedures, Volume 2: Tools, ILO/STEP, 2005.*
- Guide de gestion des mutuelles de santé en Afrique (Management guide for mutual health organizations in Africa), ILO/STEP, 2003. *
- Health micro-insurance schemes: monitoring and evaluation guide (Guide de suivi et d'évaluation des systèmes de micro-assurance santé), ILO/STEP and CIDR, 2001.*
- Reference guide and tools on health Micro Insurance schemes in the Philippines. ILO/ STEP, 2005.

MFI considering setting up a HMIS may consult in addition the following guide (that is however not specialised on Health micro insurance but deals with all micro insurance products):

- Making Insurance work for microfinance institutions, a technical guide to developing and delivering micro insurance, ILO, 2003.

NB: guides mentioned with a * are accessible free of charge on ILO/STEP website http://www.ilo.org/public/english/protection/socsec/step/

III.1 Setting-up a HMIS, some logical phases

Ideally, setting-up a health micro insurance scheme may involve those four logical phases, each phase being determinant in the success of the setting up of a HMIS. Phases such as identification (pre feasibility) and design (feasibility) may be overlapping in some cases.

Checklist box
HMIS setting up process_ simplified steps and tasks checklist

Identification
- ❑ Task 1_ Check for preconditions
- ❑ Task 2_ Confirm the relevancy of setting up a HMIS

Design
- ❑ Task 1_ Design HMIS building blocks (benefit package and premium, membership conditions, health providers payment)
- ❑ Task 2_ Define the organisational structure and governance
- ❑ Task 3_ Define the operational management
- ❑ Task 4_ Elaborate a development strategy (business plan)

Preparation
- ❑ Task 1_ Bring capacities together (set partnerships; form and train internal capacities)
- ❑ Task 2_ Prepare and set tools
- ❑ Task 3_ Fulfil administrative requirements and set appropriate institutional linkages
- ❑ Task 4_ Specifically prepare the first promotional and enrolment campaign

Implementation
- ❑ Task 1_ Promotional information campaign within the target zone
- ❑ Task 2_ Enrolment campaign and premium collection
- ❑ Task 3_ Update membership database (Monitoring and information System)
- ❑ Task 4_ When necessary, ensure additional information on entitlement to insured population
- ❑ Task 5_ Refresh different partners' information through additional training session
- ❑ Task 6_ Start of the coverage

Routine activities, monitoring and adjustments

III.1.1 The identification phase with the pre-feasibility study

The identification phase consists in checking the relevancy and the broad feasibility of setting-up a Health Micro-Insurance Scheme in a given context. This stage consists essentially in checking the pre-conditions of setting up a HMIS as presented in the first part of the guide (see section I.1.3). This stage will be critical, as it will eventually allow taking the decision to engage or not in the setting up of a Health Micro insurance scheme.

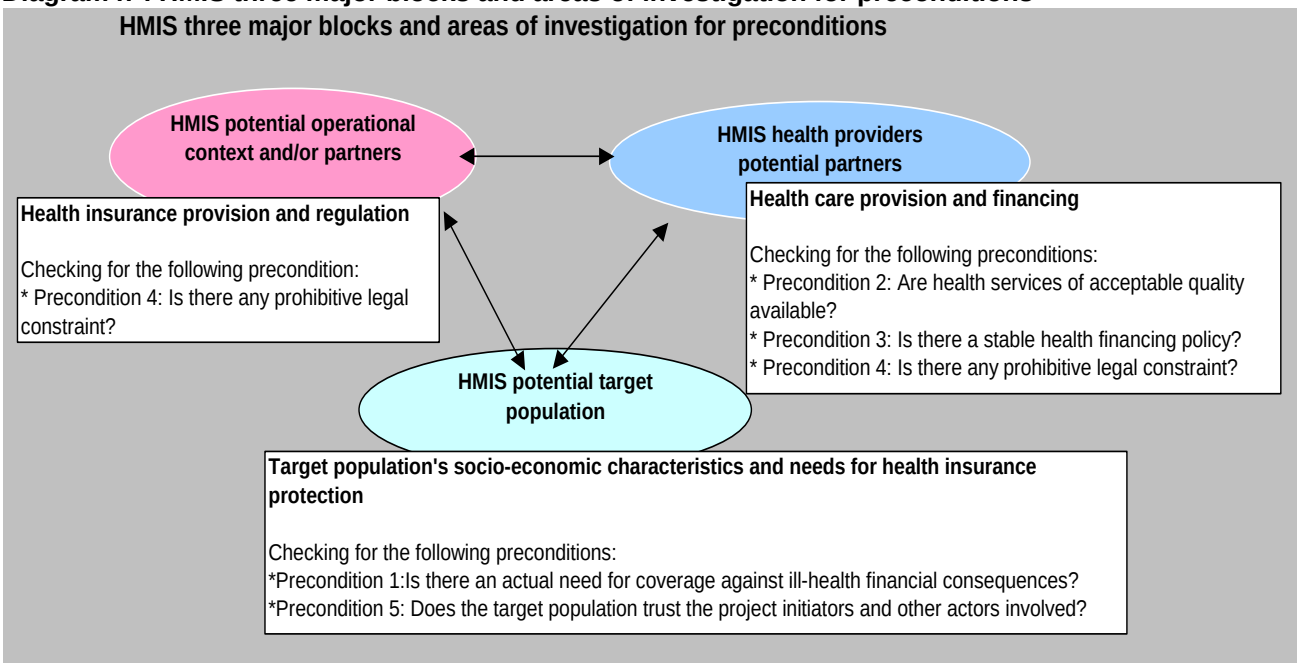
The identification phase will consist in two major tasks:

- Task 1: Check for preconditions
- Task 2: Confirm (or not) the relevancy of setting up a HMIS and form a group of key persons and target population representatives to conduct or be associated to the setting up process if relevancy is confirmed.

The identification phase is therefore dedicated to gather appropriate information that will allow deciding to set-up a Health Micro Insurance Scheme or not. HMIS potential promoters should gather at that stage selected key information related to:

- The target population's needs in terms of health insurance protection and its socio economic characteristics;
- Health insurance provision and regulation;
- Health care provision and financing.

Diagram n°: HMIS three major blocks and areas of investigation for preconditions[43]



[43] Add the 6th pre condition if needed

The identification phase can take the form of a planned pre-feasibility study when the promoting organisations are external to the context and/or to the target population. It may follow a more informal process when HMIS initiators are community-based or already familiar with the context and/or with the target population. Overall, the methodology adopted to check for preconditions will vary depending on the nature of the promoter and its resources' constraints (time, money, skills). In some cases, the identification phase or pre-feasibility study may also be conducted as the initial phase of a feasibility study (see next section related to feasibility study).

The setting up process of Health Micro Insurance Schemes originally commissioned by external donors or piloted by international NGOs will generally go through a pre-feasibility study per se and the three areas mentioned earlier and in the diagram n° _ above will be investigated in a systematic way. For Health Micro Insurance Schemes initiated locally, experience show that identifying needs may follow a more progressive process along promoters' regular activities and checking for overall preconditions may not go through a systematic process.

Case study box – illustrating diversity
Identifying needs: different promoters, different process

When the promoting organisation is community-based such as microfinance institutions in regular contact with its clients (such as ***AssEF in Benin***[44], see case study box n°_), the need for financial protection through insurance services will generally arise along regular activities in contact with the target population. In that context the actual need for health insurance is assessed through a non-systematic process and relies essentially on the accumulated social capital of the promoting organisation.

A local Ngo working at the community level on income generating activities or on sanitary conditions will have already a fair understanding of the population needs regarding access to health care. In India, ***Ashwini health insurance scheme***[45] has been initiated by ACCORD, a Ngo involved for years in health education and prevention activities amongst the Adivasi tribal group. ACCORD did not conduct a pre-feasibility per se but identified the need for insurance protection along its activities in contact with the Adivasi community. Consequently, they conducted informal consultation and progressively raised awareness and gained the Adivasi group's interest about the possibility to create an insurance fund to access appropriate health care.

A health provider that may question the possibility of setting-up a HMIS will definitely have information regarding health provision and financing issues as well as epidemiological pattern in the target zone. Besides it will have already a general picture on patients' difficulties in paying for health care. However, health providers will have little information on ill persons' reasons for forgoing care and about the general population needs in accessing appropriate health care. In the Democratic Republic of Congo, ***Bwamanda hospital health insurance scheme*** identified the need to ease access to health services for the poorest zone in its catchments area along its activities. To complete its analysis, it took one year to inform local leaders et representatives of the population in the target zone in order to raise awareness before consulting them to design the scheme and set the premium in accordance with the target population capacity to pay.

When a specific pre-feasibility can be conducted, the methodology may rely on:

- ***A preliminary review of secondary data sources*** such as national or regional socio-economic households surveys; where and when existing, national Poverty Reduction Strategic Papers may also be a starting point to approach the general socio-economic context of excluded groups and obtain a general first idea of the income levels in the target zone; national health care services coverage plan; national health strategic plan (notably health financing policy); existing reports on the country diseases burden; health system performances and general health seeking behaviours; existing reports on social security provision and extension policy, etc.

- ***A series of selected short field visits and interviews with potential key stakeholders /partners*** of the future HMIS and ***key resource persons (informant persons)*** in the health and insurance sectors at appropriate levels (at national or decentralised level) to gather essential information related to Health Micro Insurance Schemes' preconditions.

[44] Insert final CGAP reference

[45] Insert reference

Information to be collected to check if preconditions are met

During the pre-feasibility study's (or generally the identification phase) interviews and visits, a key set of topics should be raised to check that preconditions are met. The three lists presented below attempt to give an overview of key information that should be systematically checked at that initial stage. In any case those lists should be regarded as comprehensive and definitive list to be followed but should be regarded as a first draft checklist to be adapted and completed by potential promoters.

Regarding the needs of the target population in terms of health insurance protection

> **Checking for the following preconditions (see complete checklist page_):**
> - ❑ Precondition 1: Is there an actual need for coverage against ill-health financial consequences?
> - ❑ Precondition 5: Does the target population trust the project initiators and other actors involved?

- Risks perceived by the target population;
- Major illnesses afflicting the target population;
- Period of increased exposure to illnesses (such as "dengue fever period" in Cambodia, "malaria season" in Senegal);
- General health seeking behaviour for both minor and major risks;
- Health care providers used by the target population and how they are perceived;
- Health expenditure's financing at households level for minor and major risks;
- Difficulties in financing health expenditures: cases and period of increased difficulties in financing health expenditure;
- Existing mutual aid practices and/or health insurance schemes in the target zone;
- Presentation of existing health micro-insurance schemes and the principles of insurance;
- Previous experiences involving similar mechanisms initial contribution (or resource pooling mechanism) at local level and their outcomes;
- General assessment of the target population first willingness to contribute to a HMIS.

At this exploratory stage, focus group discussions[46] and selected visits of the target zone (villages, suburbs, markets, workplaces, etc.) should be appropriate techniques to approach and understand the target groups' needs and major characteristics.

Depending on the nature of the promoting organisation and the target population, approaching and understanding the target population needs will be more or less demanding in terms of preparation. If the promoting organisation is community-based (such as micro finance

[46] Methodological insights related to focus group discussion are available on the Internet. To be efficient, focus groups should be of reasonable size (generally from eight to ten persons) and discussions should be properly facilitated to draw valid conclusions from exchanged ideas and opinions. Methodological insights related to focus group discussion are available on the Internet.(INSERT RELEVANT URL)

institutions, local associations specialised in health promotion; etc.), appropriate focus groups should be easy to organise. For health providers, conducting "exit patient surveys[47]" can be one way of approaching the target population. However, as patients only cannot be representative of the population of the health provider catchment's area, additional consultation among non-patients in the community will be necessary to understand the target population's needs.

Generally, for promoters who are neither directly linked to the target population nor involved in the community such as new-coming international or local Ngos, local authorities (commune, village leaders) will generally be an appropriate entry point and support to approach the target population and to establish focus groups as well as creating trustful relationships at that initial stage. However in some contexts, the population may disregard local authorities in relation with corruption and identifying an alternative suitable media to approach the target population will be necessary.

Regarding health provision and financing of health care

Checking for the following preconditions (see complete checklist page_):
- ❑ Precondition 2: Are health services of acceptable quality available?
- ❑ Precondition 3: Is there a stable health financing policy?
- ❑ Precondition 4: Is there any prohibitive legal constraint?

Health providers level:
- Illnesses trend and pattern (morbidity burden – major illnesses and seasonal pick if any);
- Health services available;
- Health services user fees for patients (level and types);
- Existing supporting measures for indigents (exemptions, waivers, associated equity funds, etc.);
- Health provider's main issues in terms of functioning and financing (default payments proportion and existing responses if any; workload during seasonal pick and human resources shortage if any; drugs supply shortages if any; other medical and non medical equipments shortage if any);
- Already existing partnership with health insurance scheme or other social protection mechanisms;
- General insurance mechanism and examples of existing health micro-insurance schemes to secure patients' payment;
- Potential for a partnership with a HMIS (different options of partnerships, advantages and drawbacks).

National or decentralised institutional level:
- Health financing policy (current and coming reforms);
- Regulation of health care provision;
- Specific policy regarding HMIS.

[47] During exit patients' surveys, patients leaving the health facilities after treatment are surveyed about the care received, how much they paid and about their perception of the quality of care and services.

When the HMIS promoting organisation is distinct from health providers, these aspects might not be easy to tackle in a first step but are of critical importance as one of the key preconditions is the availability of health care services of acceptable quality.

Interviews with health authorities (national or local) and visits of selected range of health providers and interviews with their managers should be sufficient at that stage to provide required information.

- Interviews with all health facilities managers at the different levels of the health system in a given target zone might neither be feasible nor necessary at that stage. An introductory interview with the local health authority can be an appropriate first step to pre-select a range of health providers among the ones used by the target population. In order to perform a complete but rapid appraisal of the objective quality of the services provided in the target zone, short visits of selected health facilities (private and public) currently used by the potential target population should be conducted to complement interviews with health facilities management team. These visits may follow "patients' road" within the facility for example and be conducted with an appropriate checklist of observable key criteria to assess health services objective quality[48].

- When promoting organisations are distinct from health providers and/or are not familiar with the health policy issues in the country, it will be of paramount importance to understand health system major issues in terms of provision and financing of health care to evaluate if policy changes are planned to address financial barriers to access health care and might in consequence render the need for health insurance inaccurate. Interview with local health authorities and review of national health policy document should be appropriate source of information.

Regarding health insurance provision and regulation

Checking for the following precondition (see complete checklist page_):
- ❑ Precondition 4: Is there any prohibitive legal constraint?

National institutional level:
- Legal framework related to HMIS and insurance in general;
- Existing policy to encourage or force private insurers to service low-income populations;
- Existing possibility of exemption from financial requirements associated with the general insurance law if too constraining for HMIS;
- Social protection policy, current level of coverage and potential for future linkages with HMIS.

Insurance providers level:

[48] For a preliminary checklist, see *Health micro-insurance schemes: Feasibility study guide, Volume 2: Tools, Chapter 3. ILO/STEP, 2005.*

- Existing public and private health insurance services available in the target zone;
- Existing legal incentives to provide health insurance services to low-income populations;
- Potential interest and general opinion about offering health insurance services to the target population (excluded populations).

When the promoting organisations are not already regulated insurers and are not familiar with the regulated insurance market, they will have to check that the legal framework is not prohibitive to develop viable health insurance services for a given target population. The first step will be to identify if there is a legal framework for HMIS and if it is not prohibitive for developing viable health micro- insurance services. If there is no specific legal framework for HMIS, alternative legal status available to deliver health insurance should be identified as well as the legal financial requirements associated with each status option. In some contexts where health micro-insurance concept is nascent, possibility of exemption regarding the general insurance law's financial requirements should be investigated.

Interviews with key persons within the public authorities in charge of insurance and health insurance regulation and review of relevant legal texts should be sufficient sources at that stage to check precondition in that area.

Concluding the identification phase, deciding to set up a HMIS or not

At the end of the identification process /pre feasibility study, potential promoters should have key elements to take an informed decision to set-up or not a Health Micro Insurance Scheme. If preconditions are met, the promoting organization can decide to launch a feasibility study that will be the basis for the design of the HMIS building blocks and organisational structure.

In many cases, a genuine need for protection against ill health financial consequences will be easy to identify amongst excluded populations as described in the first part of the guide. However the demand for health insurance will generally be inexistent as a first step since excluded populations will generally not know the insurance concept at all (more specifically in rural areas in low-income countries). Therefore during the identification phase /pre-feasibility study, discussions may eventually be used as a first step to create and raise awareness of the target population about health insurance and its advantages compared to individual and traditional mechanisms to finance health care expenses. Similarly, meetings with health providers and regulated insurers should give a first opportunity to test the idea of partnerships and/or linkages with a Health Micro Insurance Scheme.

In addition, all discussions conducted during the identification phase should allow collecting data on socio-economic profile of the target population, their health seeking behaviour and the difficulties associated with illness, the health system organisation and financing. These data will be helpful for developing appropriate collection materials to be used during the design phase if setting up a Health Micro Insurance Scheme proves to be a relevant and feasible option to answer the target population needs to access appropriate health care without catastrophic financial consequences.

Identifying key persons to form a consultative group or committee to ensure a genuine community participation in the design

Eventually and importantly, during the identification phase, HMIS promoters may identify key persons from the target population (and its different subgroups), local authorities, pre-selected health providers representatives, local development representatives, religious moral authorities representatives in some contexts to form a group that can either lead the design phase (steering committee) or be associated or consulted during the design of the scheme (consultative group).

When the group is to be active in conducting the design and will act as a steering committee during the whole setting up process, selected key persons may have a certain level of education (a minimum level of education will be necessary to conduct survey for example) and have the confidence of the target population (ILO/STEP 2005[49]).

[49] ILO/ STEP (2005), Reference guide and tools on health Micro Insurance schemes in the Philippines.

Case study box
Setting up process_ *Yeshasvini health insurance scheme*

For ***Yeshasvini health insurance scheme***, in Karnataka State in India, rural households' needs have been identified through an informal survey conducted by Narayana Hridayalaya well-known hospital for heart diseases in Bangalore, to understand the reasons for under-utilisation of the surgical facilities in hospitals in Karnataka state while Indians were dying of diseases that could have been averted with appropriate surgical care. The findings revealed that the main hindrance to access surgical care was linked to households' insufficient financial capacity.

Based on the survey's findings, Dr Devi Shetty, a cardiac surgeon and head of the Narayana Hridayalaya hospital, decided to launch an insurance scheme to cover surgery procedures. He convinced the Government of Karnataka, which agreed to support the scheme to undertake the administrative tasks through the Department of Cooperatives (that are the key stakeholder to reach rural households in the Indian context). He then formed a team of doctors and officers from his hospital to identify insurers that could undertake insurance functions and hospitals that would be ready to join the scheme to provide appropriate surgery facilities within the whole Karnataka State that counts 25 millions farmers and their dependents.

Eventually the scheme could not achieve an agreement with the National Insurance Company and has to retain the insurance risk. The day-to-day management has been transferred to a Third Party Administrator[50] (TPA) - Family Health Plan Limited (FHPL) - that has negotiated and set Third Party Payment mechanism with a network of 137 private hospitals across the State to deliver surgery procedures (and associated pre-diagnostic care) at pre-negotiated tariffs.

To be continued

[50] See definition in the lexicon in annex n°_

III.1.2 The design phase with the feasibility study

When needs for health insurance protection have been clearly identified and overall preconditions are met, promoting organisations can start designing the scheme with the twin objective of efficiently answering the target population's needs and be viable in the long run.

Designing the HMIS

Designing a Health Micro Insurance Scheme should at least involve four major tasks:

- Task 1: Design the HMIS building blocks;
- Task 2: Define the organisational structure;
- Task 3: Define the operational management;
- Task 4: Elaborate a development and financial strategy (business plan).

TASK 1: Design HMIS building blocks

The core task of the design phase consists in designing the four building blocks of HMIS as presented in part II and therefore also consists in solving specific challenges associated with each block. At that stage promoters should design or review feasible options and put forward the most appropriate option(s) related to:

- Membership (conditions and rules);
- Benefit package(s);
- Premium level;
- Health benefits provision and provider payments mechanism.

This is definitely the most critical step in the setting up process, as it will heavily determine the attractiveness of the scheme and its inherent capacity to deal with specific risks of insurance:

- The membership rules have to enhance accessibility and control for adverse selection;

- The combination "benefit package - premium level" have to be relevant in terms of health services coverage, visible in term of benefit for insured and affordable in term of premium as a part of the target population's income.

- The quality of care and services covered by the HMIS is a cornerstone of the attractiveness and viability of all insurance schemes operating on a voluntary basis. When promoting organisations are distinct from health providers and in systems were insured

members will not have the choice of the health providers they use, one of the critical task will consist in selecting appropriate potential partners amongst pre-selected health facilities (during the identification phase).

- The type of contractual arrangement with health providers will also be determinant regarding the scheme's potential to remove financial barriers in accessing health care. HMIS protective effect will be highly decreased if Third Party Payment mechanism can not be arranged with health providers as insured members will still have to find necessary cash at the time of illness to pay for care and claim afterward for reimbursement. Contractual arrangements with health providers will also be determinant regarding the scheme costs control, as some payment mechanism may be prone to both patients and providers over-use of health care.

TASK 2: Define the organisational structure of the scheme

This task consists in designing the most efficient internal and external linkages to ensure that each function is properly assigned and handled to allow the scheme delivering health insurance services to the target population in a viable and efficient manner.

At that stage, promoters will have to define who will handle the core management functions (as detailed in Part II) , how and at which level of the scheme. As underlined in part II of the guide, there is no unique organisational model. There is neither no unique process of identifying the appropriate organisational model that will depend on a wide range of factors such as the objective of the health micro insurance scheme, the nature of the promoter, the general approach regarding the involvement of the target population in the management, the available skills and its costs in the context.

At the end of that stage, promoters should have identified which functions will be outsourced, to which partners according to which optimal contractual mode; and which functions will be internally handled with which human resources. For functions that HMIS will manage internally, training needs should be identified at that stage.

The choice of the legal formula should also be done at that stage. As legal requirements can have significant impact on the functioning of the scheme, the design of the internal organisation and the choice of the legal status should preferably be approached concomitantly. As underlined for preconditions, general legal aspects should be considered at the onset of the setting up process. Overall, promoters will have to define the internal organisation of the scheme in conformity with the adopted legal framework.

In order to set clear governance and line of responsibilities, promoters should at that stage define decision-making, executive and supervisory bodies that will shape the internal organisation of the HMIS as for any enterprise. HMIS internal organisation will vary greatly around those three

standard bodies that will take different forms depending of the legal status and the general mission and vision of the HMIS.

TASK 3: Define the operational management and draft core reference documents

Once tasks 2 and 3 have been completed, HMIS promoters should be in position to consolidate the whole design of the scheme by detailing the operational management that the HMIS will follow. At that stage, HMIS promoters will have to draft "reference documents" for operational management regarding:

- Internal rules (objective, functions, tasks and responsibilities);
- Content of contractual agreements with partners (such as health providers; audit companies, regulated insurers; etc);
- Core monitoring procedures (indicators to be followed);
- Manual of procedures for each function internally managed notably procedures for enrolment and claims management when directly handled by the promoters (i.e. accounting procedures).

Task 3 may be performed along the two previous tasks.

TASK 4: Elaborate a development strategy (business plan)

When the whole design of the scheme is actually drafted, HMIS promoters will have to adopt a more dynamic approach of the HMIS and elaborate a clear development strategy. A business plan should therefore be elaborated at that stage stating human, material and financial resources required to follow a given strategy at a three to five years time horizon. For more details see annex n°_ for an example of business plan standard content.

When drawing their development strategy, HMIS promoters may give special attention to:

- The promotion and communication strategy to ensure effective sensitisation amongst the target population about available health insurance services;
- The strategy to ensure that quality of health services is sustained;
- The need and possibility for re insurance should be stated;
- The specific financial support that might be needed to complement premium resources at the starting phase of the scheme as the number of insured members may be generally limited;
- The need for training and specific technical support that should be mobilised to reinforce internal management capacity should be clearly mentioned in the business plan;
- The policy regarding insurance reserves investment should be clearly defined.

HMIS promoters may for example define at that stage if the HMIS will go or not through a pilot phase with a limited geographic coverage the first years and therefore defined the associated financial needs to sustain the scheme functioning and progressive development.

Ideally, for each "benefit package- level of premium" designed scenario, HMIS promoters should estimate, very broadly at that early stage, the number of insured members necessary to reach to balance the HMIS expenditures and income. These first figures, even if they need to be considered with much caution, will give ultimate indications on the feasibility of the different scenario previously designed when the objective is to ensure:

- Attractive and efficient (actual protective effect) benefit package;
- Affordable level of premium (objectively in regard to the target population level of income and subjectively in regard to the benefit package);
- Appropriate (skilled) management to sustain the scheme viability.

The establishment of financial scenario may give indications to build strategic orientations to overcome the initial situation's limitations such as for example:

- To increase geographic coverage beyond the initial target zone;
- To relax some of the enrolment's conditions to register households beyond the target population;
- To merge, in a short or medium term, with other HMIS to reach a sufficient number if insured to sustain health insurance services' provision;
- To outsource management services to a technical umbrella covering different insurance pools (in that situation the HMIS will keep its ownership);
- Etc.

Importantly, HMIS promoters should set key indicators and reasonable targets for each development phase to assess the scheme's progress against.

HMIS promoters should also elaborate at that stage a budget for the start-up phase of the HMIS that required specific investments in terms of promotion for example.

Methodological aspects

Designing a HMIS and drawing a development strategy require to collect appropriate and valid information to gain a solid understanding of the target population's needs and socio economic characteristics, the existing insurance provision and regulation and existing health provision and financing. Collected and processed data will be used for selecting the covered services, the benefit package/premium combinations, the partner health care providers, the organisational structure and legal formula. The design phase also requires engaging a dialogue with potential partners to test the feasibility of suitable contractual arrangements.

Ideally, the design phase may be conducted along a planned feasibility study that will investigate in depth areas approached during the pre-feasibility (as presented in section III.1.1) and provide appropriate data to ensure a sound design. In that case, the pre-feasibility study would be conducted as the initial step of the feasibility study. A well-designed feasibility study should ensure that only appropriate and useful information are collected and time and financial resources are not wasted through too extensive feasibility study. Procedures and tools for feasibility study for HMIS have been extensively developed by ILO/STEP in a specific guide as reminded in

introduction of that section: *Health micro-insurance schemes: Feasibility study guide, Volume 1: Procedures, Volume 2: Tools*, ILO/STEP, 2005.

Overall, information previously gathered and contacts established with potential partners during the pre-feasibility study may be completed at that stage by:

- In-depth discussions with potential partners (health providers, insurers, third party organisation, legal authorities) to validate the selection and establish a basis for negotiation;
- A households survey within a more representative sample of the target population;
- A targeted patients survey once health providers have been selected.

Beyond the initial consultation through focus groups and surveys, the promoting organisation may adopt a participative approach at the end of the Task 1 to propose to representatives of the target population to react on possible scenario of benefit package and associated level of premium, premium payment period and procedures, etc. Adopting a participative approach is vital during the design process to increase the overall ability to answer people's needs while developing a sense of ownership of the HMIS especially for schemes where the target population is not taking part in the management of the scheme.

The design phase requires specific knowledge notably related to:

- Insurance risks management and premium calculation;
- General management issues (financial, accounting, control, human resource management);
- Epidemiological pattern; health prevention and standard treatment protocols for most frequent illnesses;
- Quality of care's assessment (when schemes promoters are distinct from health providers);
- Health providers payment options;
- Legal aspects regarding contractual arrangements.

It requires mobilising a range of skills such as:

- Analytical skills;
- Ability to conduct meetings, listen to others and engage in dialogue;
- Ability to conduct interviews, process survey questionnaires;
- Computer skills needed for data entry;
- Mathematical aptitude: calculation of indicators, interpretation of results;
- Writing skills in order to draft legal documents and prepare management tools, such as the procedures manual.

When the promoting organisations cannot mobilise appropriate knowledge and skills internally, hiring specific expertise may be critical to ensure that the HMIS can be developed based on a sound initial design. In that situation, HMIS promoters may have to mobilise or raise specific funding to access appropriate expertise during that phase.

Expert may be contracted to conduct the entire feasibility study and draft the business plan in association with the consultative group or committee. External expertise may also be mobilised to assess health providers' quality of care. External expertise is mostly mobilised to calculate the premium and elaborate the business plan. In systems where regulated insurers have been identified as partners to handle the insurance functions, they may design the benefit package and set the premium, or simply calculate the premium for the benefit package designed by the HMIS promoters such as in the Ashwhini Health Micro Insurance Scheme[51] in India for example.

[51] Insert reference

A deplacer
Story box
Setting up process _ AssEF in Benin

AssEF (Association d'Entraide des Femmes) is a microfinance institution created in 1995 that represents a network of 112 credit and saving associations (C&SA) and 26 savings and credit fund (S&CF) managed by an apex institution called AssEF. AssEF MFI only targets women in the capital city of Cotonou and its suburbs in Benin. It delivers credit and savings services to 25 000 women (in 2004) to support their income generating activities. Difficulties in paying for health care have been raised directly by women members in AssEF. Considering that health insurance services would also be useful to secure its credit portfolio (limit default payment in case of health problems), AssEF required external support from ILO/STEP Africa in 2002 to conduct a feasibility study in order to identify health risks, women's health insurance needs and to design an appropriate benefit package for a moderate premium.

The feasibility study has been conducted based on ILO/STEP methodology and needed adaptation to the context during 2002 and 2003. A steering committee gathering selected members from the Board of Directors, some technical staff and some representatives from C&S banks and associations has been formed to conduct the feasibility study with technical external support from ILO/STEP. Three pilot sites have been selected to conduct the designed surveys and start raising awareness activities at the same time.

Two major surveys were conducted:
- A survey of a sample of 480 households regarding their structure, health care seeking behaviour, financial risks linked to illness, health care providers that they mostly use, etc.
- An average health care cost survey conducted using a sample of 11 health structures and over 1,600 patients in order to determine users' health services and pharmaceuticals spending.

This phase also included awareness-raising activities by saving and credit associations and credit fund members in all three pilot areas.

Surveys findings have been reported and analysed with major stakeholders including the steering committee members and health providers to progressively draw the benefit package and the organisational framework of the scheme.

Three main steps have been followed in designing the scheme with the overall necessity to propose the lowest premium as possible for the best coverage regarding women's expressed needs:
- Design of the financial feasibility with health providers' selection, elaboration of a series of possible scenarios of health services covered and associated premium, selection of the best combination premium and health services coverage;
- Definition of the technical and organisational feasibility: definition of the management procedures and tools and its integration within the existing AssEF microfinance institution with a specific department to health insurance activities as a new activity of AssEF but with separate accounting;
- Negotiation and elaboration of the partnership contract with private not for profit health providers for a third party payment mechanism and finally the elaboration of a procedures manual for all actors involved in the health insurance activities.

Seven health centres and two hospitals have been contracted to provide the covered health services with a co-payment of 30% for insured members. The selected benefit package include the coverage up to 70% of the cost for:
- General curative consultation for adults and children;
- Gynaecologic consultation;

- Pre and postnatal consultation;
- Simple and complicated deliveries;
- Hospitalisation for medical and surgery care for adults and children;
- Essential generic drugs delivered by partner health providers.

With a focus on gynecologic and obstetric care, the benefit package's selection reflects the needs of women who are the target population of AssEF. To keep the premium low, beyond the gynecologic and obstetric services the benefit package excludes all specialist health services and prosthesis, it excludes dental care as well as brand name drugs except some specifically, delivered by contracted health providers.

The first implementation strategy was planning a test period within the three selected zones for the feasibility. The option was not accepted and the roll out of the product finally took place in all AssEF intervention areas in May 2003. However, the growth of scheme have been planned to follow a slow path with a target membership of 5% of the target population the first year and 10% the second year in order to test the product and the general functioning and procedures. End of 2004, 2,272 beneficiaries were benefiting from health insurance protection within AssEF.

The whole implementation process has been carried out by AssEF internal human resources with the technical support of ILO/STEP for the feasibility study including the design, the training of involved staff, for sensitisation and promotion activities, subsidies of human resource to implement a management information system as well as funding of the first set of tools. Besides, AssEF MFI is *de facto* subsidising health insurance activities that are part of its activities through the allocation of a reserve funds to health insurance activities and through the payment the salary of the head of department who manages the insurance activities and the time of that the MFI accountant dedicate to ensure Health insurance activities' accounting on a separate basis.

Source: AssEF's Experience with Health Microinsurance in Urban and Periurban Areas of Cotonou CGAP Working Group on Microinsurance,; Good and Bad Practices, 2005.

III.1.3 The preparation phase with the practical organisation of the scheme

Once the design and development strategy of the scheme have been planned, the preparation phase can start with the practical organisation of the scheme. At that stage, HMIS promoters should have previously made sure that adequate financial resources are available to engage in the practical setting up of the scheme and following in its implementation.

The practical organisation of the scheme may consist in four major tasks:

- Task 1: Bringing capacities together;
- Task 2: Preparing and setting tools;
- Task 3: Fulfilling administrative requirements and set appropriate institutional linkages;
- Task 4: Preparing the first promotional and enrolment campaign.

At that stage, HMIS should ensure that all necessary capacities for the functioning of the HMIS are in place and that all vital functions can be performed correctly (enrolment, premium collection, claim management, accounting and financial management, monitoring; etc.). Training existing staff on new functions, recruiting new skills and negotiating partnership will be the core and critical steps of the preparation phase.

When the promoting organisation is a Micro Finance Institution delivering micro-credit, credit officers may be trained to sell the new health insurance services and handle enrolment procedures; the accounting department staff of a cooperative may receive training to manage health insurance activities' accounting as a separate entity and issue appropriate financial statements; health providers partners may be trained to control members identity and record appropriately utilisation of care; when the future HMIS is provider-based, specific staff may be assigned to act as a focal point for insured members in the hospital premise trained to ensure enrolment and claims management; in a future HMIS designed to cover a large geographic area, insurance officers may be recruited at village or commune level (decentralised level) to ensure promotion, enrolment and premium collection.

When core functions of the HMIS such as, health services provisions, insurance functions, promotion and enrolment have been identified to be outsourced, HMIS will have to engage negotiations with previously identified partners. It will generally start by a sensitisation about HMIS specific mission regarding the protection of excluded persons and the need to answer their specific needs.

Training the future HMIS internal capacities and partners implies giving them the necessary knowledge so that they can perform efficiently the tasks required by their function. It is therefore important that the future actors and their responsibilities, functions and tasks are already clearly defined at this point.

The need for training will depend on the difference between the knowledge of the actors and the knowledge required fulfilling the tasks that are entrusted to them. Not all the actors of the Health Micro-Insurance Scheme share the same responsibilities, nor do they have the same tasks to achieve; in addition each of them has their own professional experience and knowledge of insurance. Therefore, beyond general understanding of the HMIS mission and functioning, it is generally necessary to build a training program adapted to the specific needs of each of them.

The capacity building process may consist of theoretical training in the field of intervention of actors (functional management of insurance, marketing, actuaries, accounting and financial management, control and internal audit, monitoring and evaluation), and / or practical training on the systems' procedures, on the used software, etc.

Beyond capacity building transfers, negotiating partnerships will generally be the most complex task of the preparation phase and may go through a time consuming process in some cases. Partnership negotiations are critical for the success of the HMIS and, as it will be mentioned later, the capacity of the promoters to mobilise institutional support at that stage may be of paramount importance to reach suitable contractual arrangements with partners notably with health providers.

At that stage, HMIS promoters and its partners should also set "partnership follow-up monitoring committee" to create an open dialogue with partners and hold regular meetings to ensure that contractual obligations are fulfilled and that necessary adjustments are made to strive for efficiency when difficulties arise or performances are behind targets (inappropriate quality of services, over prescription of drugs; complex claiming procedures; delay in reimbursing members; inadequate information delivered to the target population, etc.). Mission, members and functioning of those monitoring committees should be clearly mentioned in contracts signed by partners.

Overall, to bring necessary capacities together, HMIS promoters may have to:

- Finalise general functional rules and elaborate appropriate reference documents;
- Assign functions to existing staff, recruit necessary human resources and ensure specific additional training when needed;
- Train internal capacities on rules and tools;
- Negotiate and sign contractual arrangements for functions that are contracted;
- Train partners to ensure an appropriate understanding of the contractual arrangements;
- Set-up monitoring/follow up committee with partners.

Preparing and setting tools

HMIS promoters will have to ensure that major tools and documents required for the establishment and the functioning of a HMIS, as mentioned in part II of the present guide[52], are made available during the preparation phase. Most of the tools may actually be progressively elaborated along the design phase and should be finalised during the preparation phase.

A minimum of three core databases (paper or computer-based recording tools) and associated forms and receipts to record information, track transactions and follow activities, should be prepared:

- A membership database to register identification of insured persons;
- A contribution database to register premium payment and identify which members is currently entitled to access benefit;
- A health services utilisation database to register insured members utilisation of services.

For HMIS that plan to start at a large scale, developing a solid computer based information system encompassing those three databases will be absolutely vital to ensure an appropriate flow of accurate information to manage the scheme. It will be particularly important in schemes that have a greater number of transactions such as schemes collecting premium on a monthly basis and that need to have a clear situation of insured premium payment at any moment. Similarly HMIS that have contracts with health providers and/ or regulated insurers will be obliged by contract to issue accurate listing of insured persons and therefore be generally obliged to develop a computer-based information system to fulfil this obligation. For smaller schemes or schemes that start on a pilot basis, simple computerised databases on Excel or Access may be sufficient at the initial stage. It is however expected that initial paper based or computer based system will have to be progressively upgraded and refined once procedures and tools have been experimented during one insurance cycle and/or to prepare the growth of the scheme.

It is most important to set an accounting system since the very beginning of the scheme activities to ensure an efficient follow-up of income and expenditure and allow for a complete transparency towards insured members. Therefore a clear and simple accounting system should be put in place and with appropriate skills to be able to elaborate the budget and cash plan as well as to issue standard financial statements.

As mentioned earlier, once the tools have been designed, it will be critical that staffs who are to be involved in the filling of forms and receipts and, those who are to maintain the database, receive adequate training to be in position to make a correct and efficient use of those tools and respect procedures.

[52] For details consult : *Guide de gestion des mutuelles de santé en Afrique*, ILO/STEP, 2003. *Health micro-insurance schemes: Feasibility study guide*, Volume 2: Tools, ILO/STEP, 2005; *Reference guide and tools on health Micro Insurance Schemes in the Philippines.* ILO/STEP, 2005

When HMIS promoters are distinct from health providers and when third party payment arrangement have been signed, it will be critical that HMIS promoters provide appropriate tools and training to health staffs who will be in charge of controlling insured patient status (e.g. does the insured person actually have paid its premium and is eligible to access health services), record accurate information about health services utilisation by insured members (e.g. which insured members – individual card number- for which disease, for which total cost for which treatment) and bill the HMIS appropriately.

Focus box
MAS Gestion, user-friendly software for HMIS

MAS gestion is a user-friendly computer program developed by ILO/STEP. It includes a membership database in which insured members details are registered; premium payments are tracked as well as health services used by insured members. Costs, quantities and health providers are detailed for each health service used by insured. Based on the registered data, *MAS gestion* edits major indicators useful to monitor insurance activities.

The computer program also includes a basic accounting module that can generate Income Statements.

With the technical support of ILO/STEP Africa, Assef HMIS in Benin (see story box n°_) will start using MAS gestion after receiving appropriate training to ensure an accurate use of the software and to fully exploit its potential as a monitoring tool.

Fulfilling administrative requirements and set appropriate institutional linkages

To prepare the implementation of the HMIS, promoters will have to complete administrative requirements associated with the legal formula previously selected during the design phase.

In most of the contexts so far, specific legal formula for HMIS does not exist and HMIS generally remain under the status of the promoting organization (mostly cooperative, association and NGO, mutual organization) that limits the administrative requirement for the HMIS.

When no specific legal framework exists for HMIS but a commercial insurance law is prevailing, official information about the future insurance activities to local authorities in charge of insurance regulation should be made. This step may be necessary for the authorities to acknowledge these micro-insurance activities and issue a more or less formal exemption. If HMIS regulation is in the ministry agenda, it may also be most useful to initiate dialogue and exchanges to advocate for specific legal requirement for HMIS.

HMIS promoting organization will have to open its own bank account to secure the insurance fund and be able to ensure fast and secure financial transfers with partners when needed.

Importantly, HMIS promoters should at that stage seek for setting institutional linkages to enhance HMIS potential and overcome its limitations as mentioned earlier in part I and underlined in the last section of the guide.

HMIS promoters should notably try at that stage to initiate dialogue with and obtain support from:

- The Ministry of health (or its devolved institution) to encourage efficient partnership with health providers and with national programs for diseases that will not be covered;
- The Ministry in charge of social programs (or its devolved institution) to work on possible channelling of subsidies to integrate the poorest groups;
- The Ministry in charge of social security (or its devolved institution) if any to acknowledge possibilities of linkages in the long term.

Support may be sought by individual schemes or/and, when existing, through umbrella organisations that have developed an advocacy mission. In some countries, government may have initiate specific initiative or legal entity to deal with HMIS. In that regard, Senegal has developed

However, such institutional support will be beneficial under certain conditions. When government bodies are distrusted or highly dysfunctional, looking for such institutional linkages might be counterproductive for the viability of the HMIS.

Preparing and organise the first promotional and enrolment campaign

During the preparation phase, HMIS promoters may give a particular focus to the conception and preparation of a well-target promotion campaign and tools with the twofold objective of:

- Stimulating enrolment amongst the target population;
- Ensuring that the population receive accurate information to understand the actual services covered and the functioning of the scheme.

HMIS may design the promotion campaign and tools in consultation with of the target population representatives and associations that are familiar with social marketing and appropriate methods to deliver information to a given target population. Depending on the cultural context, the resources and skills of the HMIS promoting organisation, communication procedures may consist of meetings with neighbourhood associations, cooperatives, reunions organised in collaboration with health centres, information campaigns on e.g. markets or at special events, radio broadcast; theatre plays, or even by house-to-house visits to potential members.

The malfunctioning of the first days or weeks after implementation of the scheme can cause a loss of confidence of the target population and the members, notably if insured members encounter difficulty when accessing health facilities. For example, for a HMIS providing free access to primary health care with a waiting period of two months, if insured members are inappropriately informed during the promotion and enrolment campaign, they may expect to have free access to health care as soon as they are registered and will be highly dissatisfied with the scheme if they realise later that they actually cannot have free access to the health facilities the

first two months as they were not aware of that condition. Similarly, if health providers are insufficiently informed about services covered for insured, the scheme runs the risk that health providers incorrectly refuse the coverage of a given health service and generate damageable dissatisfaction among insured members.

To avoid that the first promotion and enrolment campaign generates misunderstanding and dissatisfaction amongst insured and the target population, HMIS promoters should pay attention to provide appropriate training and to conduct rehearsals to check that all actors (facilitators charged with promotion, management staff, health staff of contracted health facilities) know in sufficient details the benefit package and the management procedures before the start of the activities.

Case study box
Setting up process _ Community Based Health Insurance Scheme in Lao PDR

"The Ministry of Health and World Health Organization Project followed a series of steps to assure smooth implementation of CBHI in the three pilot areas, with the understanding that the future expansion of CBHI will be developed from this experience. These included:

Community consultation
Consultation through Focus Discussion Groups
Collection of information on population size and structure
Rapid Family Survey on health seeking behavior, income and expenditure, and willingness to pay for health insurance

Adaptation of the design of the CBHI in each location
Determination of contribution and capitation amounts
Decisions on contracting hospitals, and contract negotiations
Adoption of essential drug list for health insurance benefits
Observation of the Revolving Drug Funds operation in each location
Formulation of CBHI regulations, approved by the Ministry of Health
Definition of role of district administration in CBHI
Definition of the role of Ministry of Health as policy maker, accreditor, supervisor and evaluator of CBHI

Preparation for implementation
Development of the information system
Job descriptions of staff working in CBHI
Preparation of contracts with providers
Training on health insurance and capitation payment
Installation of telephone line where necessary and provision of fax machine and filing cabinets and filing materials.

Public awareness campaign and pre-registration
Set up of Management Committee for CBHI
Job description and training of collectors
Campaigns to inform the public "

Source : quoted from COMMUNITY BASED HEALTH INSURANCE
LAO PDR: Review of CBHI pilot scheme Project MOH - WHO August 2004 Dr A. Ron

III.1.4 The implementation phase with the launch of activities

Once the preparation phase of the scheme is completed with contractual agreement signed, internal resources trained, insurance tools as well as management tools made available, the HMIS can start its activities.

The implementation phase may include seven major tasks:

- Task 1_ Official launch of the HMIS;
- Task 2_ Promotional information campaign within the target zone;
- Task 3_ Enrolment campaign and premium collection;
- Task 4_ Update membership database (Monitoring and information System);
- Task 5_ When necessary ensure additional information on entitlement to insured population;
- Task 6_ Refresh different partners' information through additional training session;
- Task 7_ Start of the coverage.

Official launch of the HMIS

The launch of the activities may give rise to a more or less official event. This can take place for example the day before starting up the procedures of enrolment or the day of the signature of partnership notably with health providers. It can be open to all the population or only to a selective list of invited people (local and health authorities, coordinators of health care facilities, health care staff, representatives of cooperatives, associations, syndicates, etc.). For HMIS based on democratic governance (such as cooperative and mutual benefit organisations), the official set-up of the scheme is generally carried out during the constituent General Assembly that gather the members or shareholders (or their representatives). When possible, HMIS promoters may gain in organising an official launch gathering its partners and the target population around a special event to increase the target population's confidence in the scheme.

When HMIS functions with a close enrolment period adjusted to the target population favourable period of cash flow, the launch of the activities should be planned adequately.

Promotion campaign, enrolment and premium payment

The promotion campaign, the start of the enrolment procedure and the collection of the premium should follow the official launch of the scheme. For HMIS functioning with a closed enrolment period, a rather intensive promotion campaign may be conducted before the registration period.

When the enrolment period is open, promotion campaign may be conducted along a more continuous process.

The enrolment can take place in a certain number of branches: the premises of the health micro insurance scheme or the organisation responsible for the promotion of the scheme, health facilities, the premises of different partner organisations (e.g.: cooperatives, syndicates), etc.

The staff responsible for enrolment procedures need to have a certain number of tools at their disposal in order to carry out necessary verifications (official family book or local census when existing), register the members and their dependents, and afterwards follow up the number of persons covered (to check insured identity, membership sheets and registers).

The staff responsible for enrolment procedures need blank membership cards to issue insured members proof of entitlement i.e. health insurance card or family health insurance card; Insured members should also receive a booklet with information on guarantees, services and tariffs, the internal rules of the health micro-insurance scheme or the contract. They may also receive, various forms (e.g. form of prior agreement), the list of registered health facilities, certificates of payment of membership fees and of the first contribution (invoices). At that stage, insured members should be clearly informed about the waiting period and the starting date of the health insurance coverage.

When there is a yearly payment, the premium is paid at the moment of the enrolment (and every year at the day of renewal). When the payment is spread, there can be several payments during the waiting period or along the year through monthly instalments. In both cases the actors responsible for the premiums collection need to have a certain number of tools at their disposal (premium sheets, premiums register, membership entitlement monitoring chart and benefit monitoring chart).

At the end of the enrolment period, HMIS promoters have to ensure and control that data related to membership and contribution have been registered correctly and that insured listing can be issued with a mention of their eligibility status (regarding premium payment and waiting period).

Case study box
Promotion campaign

SKY GRET *HMIS*[53] promotion strategy has evolved with its enrolment system. At its initial and pilot phase (1999-2004) SKY GRET HMIS adopted a multi-stage information session approach, with temporary recruited promotion task force responsible for generating interest in the insurance and to answer questions. These promoters, in agreement with the community head, organized a group meeting in villages where the scheme was to be active in order to explain the basics of the insurance. Using a graphics-intensive presentation, the promoters explained the principles of insurance, how GRET SKY HMIS worked, and how benefits will be provided. A week after this initial meeting, the promoters were returning to the village to have discussions with individual families. At the end of these discussions, the families were informed that the insurance agent – responsible for selling policies and collecting premiums – would return the following week to ask if they want to purchase a policy. Families were encouraged to take an appointment with the insurance agent who was enrolling people at home. This promotion and enrolment campaign was adapted during the pilot phase that was functioning with closed enrolment period twice a year.

After that pilot phase and after reinforcing its management information system, SKY GRET HMIS has moved towards an open enrolment in 2004. The local insurance agent regularly tours the target zone to ensure that non insured families are well informed about the existing health insurance services and about the possibility to join monthly and register people when the wish to join. In addition, the insurance agent is located every morning in the nearest health centre (primary health care partners) to enrol potential insured and maintain constant contact with partner providers and with current insured members.

Sources: GRET 2005, unpublished, Micro assurance santé au Cambodge (SKY), présentation du projet mené par le GRET (Groupe de Recherche et d'Echanges Technologiques). USAID: 2000. A cautionary note for Microfinance Institutions and Donors Considering Developing Microinsurance Product. Microenterprise Best Practices, DAI.

Start of the coverage

As soon as insured members are enrolled and have received their health insurance card or family health insurance book, they will have to complete the waiting period, if any, before being eligible for health insurance coverage.

When waiting period are set, HMIS promoters may make use of that period to refresh insured members' knowledge on health services covered, exclusions and claiming procedures when needed or to conduct health promotion and education activities amongst insured members.

When a third party payment mechanism has been negotiated with health providers, HMIS managers may also use this period to refresh training of health providers' partners and provide them with accurate insured members listing.

Once the waiting period is over, the member and his/her dependents will be eligible to access the health services as defined in the benefit package and the HMIS will enter into a routine phase including continuous monitoring activities.

III.1.5 The routine phase, monitoring and adjustments

Once the scheme has been launched and routines activities are ongoing, a vital task for HMIS promoters is to initiate and sustain an internal control system as well as a monitoring and evaluation system (see part II page _of the guide for a brief presentation of those tools).

Health Micro Insurance Scheme will be relevant and viable if it can answer its target population's needs and control for insurance specific risks. As seen in part II, the capacity of the HMIS to fit the target population's needs and to control for insurance risks is grounded in its design. It is equally grounded in its ability to perform relevant needed adjustments in the benefit package or/and the procedures once the activities have been launched. In that regard, ensuring appropriate internal control and monitoring is of paramount importance once the activities have been launched.

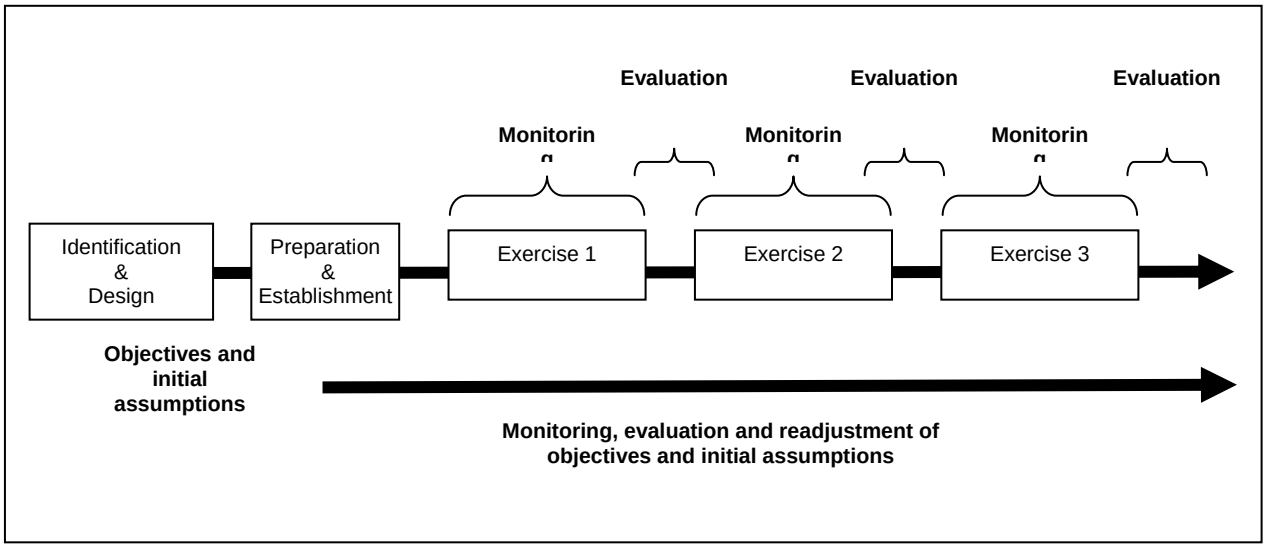
At that stage, HMIS managers should ensure that:

- The information system generates relevant, valid and complete data in a timely fashion (implying that the registration, verification and monitoring tools used for the membership, premiums, and claims management as well as for the financial management are established and used correctly);
- The generated monitoring information are effectively analysed periodically (implying that monitoring board are generated for a key set of indicators) by HMIS managers;
- That appropriate attention is effectively given to identified problems and adequate adjustments are made in the design and functioning of the scheme.

More intensive internal control and monitoring is generally required during the first year of activities as it will be critical to check whether:

- Health insurance services are actually affordable for the target population;
- Insured population is satisfied regarding the benefit package protective effect and general quality of health insurance services;
- Health providers are providing the expected quality of care as contracted for;
- The premium level is adequate (based on actual utilisation of health care services, average cost of health services, administration costs level) to ensure the financial viability of the scheme for the designed benefit package;
- Insurance risks (adverse selection, moral hazard, fraud) are efficiently controlled for;
- Internal functioning is respecting set internal procedures and is cost effective.

Based on monitoring data and additional survey, periodic evaluation process should be conducted annually to assess HMIS progress towards its general objectives; assess whether objectives and targets set for the period have been achieved or not and identify reasons for variations between the actual level of achievement and the forecasts. When possible, external evaluation should be organized to ensure objective analysis of the HMIS performances. Generally, external financial audit may be legally required.



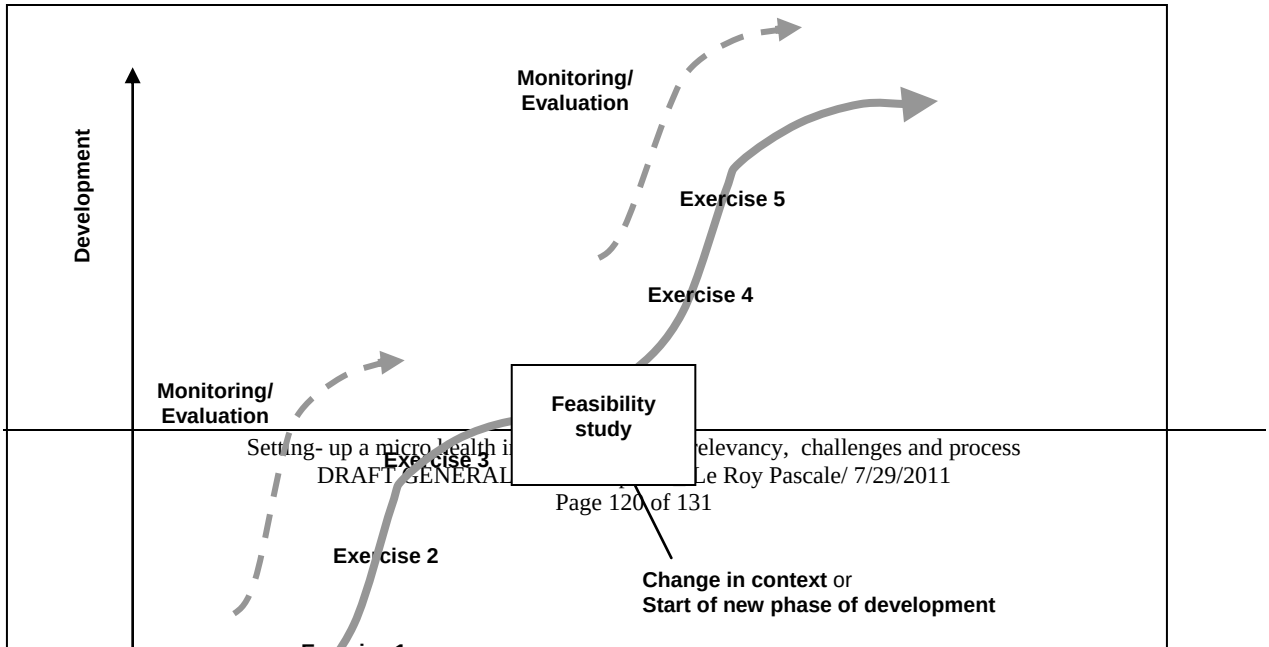
Monitoring and evaluation results should be made available to representative of the target population on a regular basis to ensure transparency towards the use of their premium and enhance the scheme's responsiveness to the target population needs.

Checklist box
Aspects that may be assessed during an evaluation process:

- Evaluate the **administrative viability**; it can measure the monitoring of membership, premiums and claims management functions, as well as the monitoring of accounting registration, budget and cash flow set up by the management of the health micro insurance scheme.
- Evaluate the **technical viability** that relates to the capacity of the health micro insurance scheme to control the risks inherent to insurance, i.e. in particular the risks of over-consumption, over-prescription and adverse selection. It consists of controlling whether the health micro insurance scheme has taken adequate measures to limit these risks and whether the measures are effective.
- Evaluate the **functional viability** that is the capacity of the scheme to respect the basic principle of the insurance, i.e. to deliver the benefits in exchange of the premiums.
- Evaluate the **financial and economical viability** that is the capacity of the scheme to insure sustainable coverage of the health care services and to face the financial commitments in the predefined period.
- Evaluate the **institutional viability** that relates to the organization of the tasks, the management of the human resources, the existence of links with other activities of the HMIS promoter, the relation of the scheme with the health care facility and the legal and regulatory framework of the scheme's functioning.
- Evaluate **the effectiveness** of the health micro insurance scheme in achieving its objectives, the efficiency of the scheme, i.e. its capacity to provide the best services at a lower cost and the impact of the scheme; its direct and indirect effects on the persons covered, on the health care facility, on the population of the region, etc.

Source: Health micro-insurance schemes: monitoring and evaluation guide (Guide de suivi et d'évaluation des systèmes de micro-assurance santé), ILO/STEP and CIDR, 2001.

As setting-up a HMIS involves to deal with a certain level of uncertainty related to insured behaviour regarding health care utilisation and management costs, it can be expected that the setting-up process will be more an iterative process than a linear one and that most of the HMIS will go through adjustments in their design and functioning after the launch of the activities as schematise in the following diagram.



Case study box
Examples of adjustments to improve initial design:

Adjustment in the functioning to manage insurance related-risks

In the Democratic Republic of Congo the provider-based HMIS, ***Bwamanda*** HMIS decided in 2004 to add a photo to the insured identity card in order to limit fraudulent use of health care previously identified through monitoring. Adding a photo to the membership card did generate additional cost for the scheme but unexpectedly raise the attractiveness of the scheme as people were very interested in getting a picture as most of them has never had a picture of themselves before.

To enhance enrolment without jeopardising its viability, ***Novadeci*** HMIS in the Philippines withdrew the pre-membership medical examination that appeared to be a significant hindrance to enrolment as potential insured declared having no time to undertake it. The pre-membership medical examination was replaced by the introduction of a waiting period for a range of selective diseases that would have been prone to adverse selection.

Adjustment regarding the benefit package

The inventory conducted by ***La Concertation***[54] in eleven African countries revealed that for half of the HMIS reviewed, the benefit package evolved after the launch of the scheme. For half of them the evolution brought additional services covered such as the introduction of primary health care in the package or additional ancillary services to better meet people needs.

In the Philippines, ***Novadeci*** HMIS improved the number and kind of available services in its clinics to better suit members needs express during their visit in the clinic. Conversely, in Nepal, ***PHECT*** HMIS started with a very comprehensive benefit package to primary health care in its clinic and hospital care in Kathmandu Model Hospital with free access. After several months of activities PHECT restricted its level of coverage free of charge access to 50 to 80% coverage. It also excluded some services regarding disease investigation, radiology and pharmacy services as over-consumption and fraud were observed.

Adjustment of the premium level

In most of the schemes reviewed, the premium level has been evolving along the benefit package improvements or to adjust the level to the actual use of the health care benefit experienced during the first years of activities. In some cases such as in ***GRET SKY*** HMIS, the premium first evolved with the benefit package improvement and at later stage to move towards financial sustainability after a period with a subsidised level of premium to encourage enrolment. In India, in ***Ashwini*** HMIS that has outsourced the insurance functions to a regulated insurer, the premium is smoothly increased mostly every year since the start of scheme in 1993 to increase the financial autonomy of the scheme that is highly dependent on donors funding to pay the amount of premium due to the regulated insurer.

Sources:

[54] For more information consult the website: www.laconcertation.org

III.2 Setting-up a HMIS, a significant and long-term investment

The development of HMIS in many LMIC has gained some experience but is still at its infant stage (at least in most low-income countries). No ready-made successful package exists (and should not be expected) to ensure the setting-up of viable and efficient HMIS to protect excluded population against ill health financial consequences. Nevertheless some general lessons such as: the need for a sound design, appropriate management skills and efficient partnership with health providers, start to emerge from the analysis of existing HMIS and should be considered by potential HMIS promoters.

Broad lessons for relevant and viable HMIS:
- A sound design
- A "professional" management
- An efficient partnership with health providers
- A long term financial strategy
- A significant institutional support with a long term strategy for social protection

Overall, experiences so far show that setting up a HMIS represents a significant investment that calls for supportive partnerships between promoting organizations and donors, technical support agencies, as well as enabling institutional linkages with government in the field of social protection and health.

III.2.1 A sound design and appropriate managerial skills

Experience so far has shown that HMIS failures and weaknesses are mostly linked to design defaults and lack of appropriate managerial skills to ensure adequate management and control over insurance risks [Bennett et al., 1998, GTZ, 2002].

Health Micro Insurance Scheme will be relevant and viable if it can answer its target population's needs while controlling for insurance specific risks. The capacity of the HMIS to fit the target population's needs and to control for insurance risks is grounded in its design and, further in the process, in its managerial capacity to ensure effective internal control and monitoring to fulfil the scheme's mission and sustain its viability.

Engaging in the setting up of a HMIS does require that specific attention be given to the design phase. The need to mobilise appropriate skills and knowledge along the whole setting-up process should be acknowledged and planned for to ensure that a given HMIS can start with an optimal

design in a given context. Beyond the scheme design and preparation initial requirements, the complexity of the insurance business will demand a skilled management with appropriate human resources and tools to run and ensure the development of a sustainable HMIS.

Developing relevant insurance knowledge and skills is expensive and depending on the insurance model selected may exceed the capacity of the HMIS promoter. When appropriate skills and knowledge required for the design and the management of the scheme are not available nor within the promoting organisation neither locally, setting-up a HMIS will require an initial investment to search for technical support and mobilise necessary external financial support. This situation may be more common for potential promoters in low-income countries than in Middle Income Countries.

Experience and literature reviewed show that revenues are usually coming from the implementing, mother organization (community based organization, health care providers, microfinance institutions etc.) or from an external partner organization (NGO, State, donors, etc.), since the scheme hasn't started its operations and cannot therefore finance the preliminary activities.

Skilled management requirements raise the discussion about the trade-off to be found between voluntary work to limit management costs and salaried work to sustain managerial capacity in the scheme.

Discussion box
Some elements for an optimal design?

- Family membership;
- Affordable premium level with family premium package to encourage large families membership;
- Simple but comprehensive benefit package including free access to essential primary health care services and hospital care of good quality in subsidised facilities including generic drugs only and mandatory referral;
- Third party payment contractual arrangement with a capitation payment to contain costs (essential to provide free access and avoid co-payments);
- Target population sense of ownership through regular consultation from the design stage;
- Skilled management with limited administrative costs;
- Independent and separate management from government and other bodies;
- Sustainable government (and donors) support to subsidise membership of the poorest.

III.2.2 A long term financial strategy

Engaging in setting up a HMIS requires building a financial strategy to mobilise appropriate financial resources for the setting up process itself and for the first years of functioning of the scheme.

Experiences reviewed show that the setting up process, from the identification of the needs and other preconditions until the launch of the activities, generally takes one-year time (more or less) and is definitely time consuming for the members of the promoting organisation. Within the process, conducting a feasibility study will generate specific expenditures such as: costs of staff (compensation for surveyors and possibly for the members of promoting organisation who are in charge of the study), training costs, travel expenses, stationary (photocopies, printings, etc.), and infrastructure costs (e.g. renting rooms for meetings and trainings). The start-up costs associated with the preparation of the management tools and the setting-up of the information system will also have to be financed before premium can be collected.

Besides, during the first years of operation, HMIS membership will generally be limited and therefore the share of the premium revenues allocated to the management costs will be relatively low even if the premium has been positioned at a suitable level to ensure financial viability on the long run. As skilled management is critical but signifies that sustainable resources are to be allocated to finance specific staff, it will be most important to ensure that financial resources can be mobilised to cover the part of the operating cost that the premium will fail to cover until the HMIS cover a sufficient pool of persons.

When engaging in the setting up of a HMIS, promoters will have to ensure that sufficient financial resources will be available to cover:

- Identification costs;
- Design costs;
- Start-up costs (preparation and implementation);
- Operating costs or part of them during the first years;
- Catastrophic risks costs.

Some HMIS may be designed as non self-financing (the premium level is intentionally not positioned to cover all the costs of the scheme) but be financially sustainable as stable and sufficient financial support has been planned to complement the premium revenues in the form of local government social grant, free human resources allocation, free office rental, etc.

Engaging in a setting-up process without an appropriate financial strategy may be highly prejudicial for insured population and the whole reputation of the “HMIS industry” if it implies for example the non-compliance in the contract with health providers (delay or default in payment) and the breakdown in the benefit provision. Insurance regulation is generally in place to protect insured members against financially unsteady insurers and/or misleading sales practices. As in some countries commercial insurance regulation may not apply to HMIS and specific

regulation may not yet be in place to enforce minimum prudential standards, potential HMIS promoters should build a responsible financial strategy when deciding to set up a HMIS.

Since HMIS promoting organisations from the civil society may generally not have adequate human and financial capacity, there is a critical role to play for technical cooperation agencies and donors to technically and financially support the setting up process and the development of sustainable HMIS.

In that regard, there is an important stake for both donors, technical cooperation agencies and promoting organisations to build partnership over a sufficient period of time that will allow the scheme to grow and reach a sufficient number of insured to be financially autonomous while answering the target people needs in terms of insurance protection. There are lessons to be learned regarding best practices in accompanying the development of HMIS without distorting its chance to be autonomous and viable in the long run which does not mean that it will function without subsidies in the long run for poorest excluded fraction of the population.

Overall, setting up a HMIS requires adopting a long-term approach.

Case study box
Pilot testing phase and long-term financial strategy

SKY HMIS supported by GRET in Cambodia went voluntarily through a pilot-testing phase in order to refine the design of the scheme, test the general functioning, recruit and train a local team, consolidate the benefit package and the partnership options before preparing the growth of the scheme. During that pilot phase and until the scheme reaches a sufficient number of insured, SKY HMIS management costs are subsidised as well as the expatriate technical assistance. In 2004, the collected premium was already almost covering the costs of the benefit package (that is the capitation provided to health providers for each insured persons). Strong financial partnership with donors is expected to accompany the growth of the scheme over a sufficient period of time to grow and hopefully achieve financial autonomy with the sole premium and possibly donors or State's subsidies to integrate the poorest segment of the rural population.

Similarly, ***WIMO SEWA*** insurance scheme "financial resources are derived from premiums, investment income, donor support, insurance company subsidies and expenses allowances, and a contribution to capital by members. The premiums charged by WimoSEWA cover the cost of the premiums paid to the insurance companies, and are providing a small margin towards administrative expenses. Investment income derived from donor grants has contributed to a positive financial result." (Garand D. CGAP, 2005) WIMO SEWA business plan set in 2001 and reviewed in 2005 assumed that seven years will be necessary for the integrated insurance scheme to scale up to 300 000 insured and reach viability. Therefore, sound management, appropriate investment policy and sufficient and stable donors' support is required over a long period if the objective is to build a financial viable (and autonomous) insurance scheme offering an integrated and relevant protection to self-employed women and their families.

Sources:

III.2.3 A significant negotiation process with partners (contracting health care providers)

When core functions such as health care services provision and insurance underwriting are outsourced, setting up a HMIS will generally require a significant investment in negotiation to obtain suitable conditions and performances from contracted partners.

For HMIS that are not provider-based, setting-up a HMIS will generally require a rather long negotiation process to set efficient partnerships with health providers. Partnerships conditions will significantly impact on the performance and the viability of the insurance scheme as they will be determinant regarding:

(1) The scheme's potential to remove financial barriers in accessing health care;
As already underlined, HMIS protective effect will be highly decreased if Third Party Payment mechanism cannot be arranged with health providers as insured members will still have to find necessary cash at the time of illness to pay for care and claim afterward for reimbursement.

(2) The scheme's capacity to contain and control costs;
When third party payment can be negotiated appropriate provider payment can limit incentive for overuse or over-prescription of health service. Providers' reimbursement on a fee-for-service basis will give more incentives to supply- induced demand (over prescription of drugs or diagnostic exams for example) than prospective payment on a capitation basis that transfers the financial risk of overused and over-prescription on health providers.

(3) The scheme capacity to control for health care quality of services;
As already underlined, the attractiveness and viability of voluntary health insurance schemes such as HMIS highly depend on the quality of health care services they will propose in their benefit package. Partnership with selected health providers will confer a greater potential for HMIS scheme to control for quality of care notably in context where health providers face a competitive market and will strive for cost effective services to ensure partnership renewal to keep insured members 'clientele.

(4) The scheme's attractiveness;
The scheme attractiveness will be increased if Third Party mechanism can be negotiated, as insured will have free access to health services covered or only a co-payment to pay at the time of illness.

Genuine partnership with health providers will be a critical factor for the viability and efficiency of the HMIS and setting-up a HMIS will consequently require building a negotiation power.

Some factors may increase the capacity (bargaining position) of the HMIS to negotiate appropriate partnership conditions (such as third party payment mechanism; tariffs discount; capitation payment, etc.) such factors can be HMIS internal factors or related to the health provision and regulation environment:

(1) Large pool of insured

A large pool of insured persons represents a potentially larger source of "captive" patients and therefore will potentially secure a greater share of its revenue if an exclusive agreement is set with the HMIS;

(2) Appropriate tools to control for fraud on insured identity and coverage

HMIS that issues insurance card with photograph, accurate listing of eligible insured on a regular basis and can delegate staff in case of litigious cases, will be in position to guarantee health providers a rather high control on potential fraud that may facilitate partnership agreement; health providers may actually require such guarantee against fraud as contractual conditions.

(3) Under-utilised health providers and competitive health provision

Health providers that are under utilised and strive to increase their activities will be more likely to accept a third party mechanism to potentially gain more patients (part of insured might previously not have access to the facilities); in opposite health providers that are understaffed and/or overloaded might be more likely to refuse contracting with a HMIS as insured members will be expected to have an increased use of health care; health providers that face a high rate of default payment may be particularly willing to set partnership to increase patients 's solvency.

(4) ***Public health and patient oriented providers***

Public providers and not-for-profit providers (such as confessional health providers) that pursue a public health mission[55] should be potentially more responsive to HMIS effort to increase access to health care to excluded persons; if significantly under funded they may in opposite be reluctant to provide discount on tariffs or to accept a capitation payment mechanism that transfer the financial risk on health providers; in that situation appropriate support from ministry of health and local health authorities will be required if such facilities are in a monopolistic position like in many rural areas in low income countries.

(5) Substantial support from health authorities

Health authorities' support to HMIS mission is a critical parameter in the negotiation process between HMIS and health providers, such support can encourage health providers to set partnership contract with favourable conditions for HMIS in regard to their social mission to serve excluded groups and therefore to keep their level of premium at a moderate level for the more comprehensive benefit package as possible.

There is definitely an important role to take for ministries of health regarding the development of appropriate health providers' payment that will help maintaining HMIS affordability and accessibility. There is a potential positive synergy between public health providers and HMIS to reinforce each other that HMIS should put forward in their negotiation process with health providers.

HMIS that approach their role along a public health mission should become privileged partners for health authorities, as contractual agreement set with health providers will bring the twin advantage to:

- Channel insured patients to public facilities (that might be underused) instead of using private providers that might be unregulated and providing inappropriate (at least uncontrolled) quality of care;
- Secure a (potentially increased) part of public health facilities resources (however it does not replace public funding but channel more appropriately households out-of-pocket payments).

However, where health provision is poorly regulated it might be difficult to mobilise effective institutional support when negotiating with private providers and other elements may have to prevail in the negotiation process.

Case study box
Favourable factors when negotiating partnerships

In the case of ***Yeshasvini*** in India, the experience of the Third Party Administrator - Health family Plan Limited- and the size of the potential insured pool (the whole Karnataka State that counts 25 millions

farmers and their dependents) allowed reaching a third party payment mechanism agreement with a network of 137 private hospitals (private hospital that are generally under used, see story box n°_ on Yeshasvini) with significant tariffs reduction on surgical procedures covered.

For ***GRET SKY*** HMIS in Cambodia, the Ministry of Health Institutional strong support as well as the support from medical NGO backing public health providers and UNICEF have been critical in the successful negotiation with public health facilities at district level for a third party mechanism based on a capitation payment (that actually transfers the financial risk to health providers).

!!!! For HMIS outsourcing insurance risks

III.2.4 An appropriate institutional support within a long term approach for social protection

Overall, setting-up a HMIS will require building appropriate institutional linkages and mobilising appropriate institutional support to fulfil its mission and more specifically to:

- Operate under favourable legal status (obtain exemption when needed);
- Access similar device as re-insurance mechanism for non commercial insurer (guarantee fund, specific emergency fund);
- Build favourable and efficient partnerships with health providers and regulated insurers when needed;
- Benefit from public health programs support to deal with chronic diseases and develop prevention activities for insured members;
- Access social assistance fund to include the very poor households in the insurance pool.

The previous list of areas where HMIS needs support stresses the significant role that government have to play in creating an enabling environment when the development of HMIS is approached as a strategy to move towards universal coverage.

For HMIS that are not stemming from government initiatives, it will be critical that promoters should try to obtain support from:

- The ministry of health (or its devolved institution) to encourage efficient partnership with health providers and with national programs for diseases that will not be covered;
- The ministry in charge of social programs (or its devolved institution) to work on possible channelling of subsidies to integrate the poorest groups;
- The ministry in charge of social security (or its devolved institution) to acknowledge possibilities of linkages in the long term.

The HMIS capacity to mobilise such institutional support will be a significant favourable factor for the development and the viability of the scheme. Support may be sought by individual schemes or, when existing, through umbrella organisations those have an advocacy mission and are recognized as credible partners by public authorities.