



## Methodological guide for undertaking case studies

• Health micro-insurance schemes •

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**July 2000**

Strategies and Tools against Social Exclusion and Poverty Programme  
Planning, Development and Standards Branch  
Social Protection Sector  
International Labour Office

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In the spirit of ILO's concrete contribution to the World Summit for Social Development (1995) and to its follow up through «Geneva 2000», the STEP Global Programme promotes the design and dissemination of alternative schemes to extend social protection to the excluded. These schemes are based on the principles of equity, efficiency and solidarity. They contribute to social cohesion and social justice.

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## 1. Introduction

This guide was created by the global programme Strategies and Tools against social Exclusion and Poverty (STEP) of the Social Security Department of the International Labour Organisation (ILO). STEP is a programme whose activities concentrate particularly on extending social protection, by researching efficient innovative strategies and mechanisms destined for populations excluded from existing systems.

One of the strategies developed by the programme is to document the innovative experiences related to extending social protection. For this reason, one of the programme's tasks is to develop methodological and informative tools. This Guide was conceived to facilitate the implementation of these studies and to provide a common methodology, which would allow the comparison of information collected. It is presented in three languages: French, English and Spanish<sup>1</sup>.

In the field of health, STEP pays particular attention to decentralised insurance systems termed micro insurances as one of the mechanisms of extending social protection. These innovative systems are relatively poorly documented and it is because of this information deficiency, that STEP has globally launched a series of studies on these systems.

Moreover, this methodological Guide aims to provide a description of the systems studied and an appreciation of their manner of operation. It does not seek to evaluate the systems, neither in terms of impact, nor in terms of efficiency of the health sector.

The Guide is primarily destined for those responsible for implementing case studies. It will indicate precisely the information to be collected. In the same way, the user will find precise information on how to elaborate the analysis report.

Before beginning to prepare a case study, it is crucial that the complete Guide is read. Afterwards, users will have to consult the various parts during their investigations.

## 2. How the guide should be used and the case study report produced

### 2.1 The various parts of the guide and their use

#### a) *The Outline Plan*

The outline comprises the following sections:

- Part A: Synthetic Description of the Health Insurance System
- Part B: The Context in which the Insurance System Operates
- Part C: The Creation of the Health Insurance System
- Part D: The Insurance System's Characteristics
- Part E: The Indicators of the Insurance System's Operation

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<sup>1</sup> The Spanish version is the product of an adaptation produced jointly with the Pan American Health Organisation (PAHO), Regional Office for Latin America and the Caribbean of the World Health Organisation (WHO). The English version is a translation.

## Part F: The Actors' Points of View vis-à-vis the Insurance System

The outline specifies the information that the study will have to integrate and examine. It is identical to that of the study's report. Ideas on how to develop the outline into the study are given below in section 2.2.

It is not an easy task to standardise the information to be collected since it is so diverse. However, the outline has been designed with this diversity in mind. It covers a broad range of situations. Nevertheless, it has not projected all possible occurrences. Further, certain questions included may not be pertinent (or formulated using adequate terminology) to a given insurance system. The study's authors, in order to represent the particularities of the system studied, have thus to add certain points and delete others. These additions and deletions should be done according to the format presented in paragraph 21 below.

As stated in the introduction, the case studies do not intend to evaluate the scheme. However, they should provide a good description of the schemes studied and allow an appreciation of the quality of information available. Afterwards, more in-depth studies, which would lead to an evaluation of the impact and efficiency, could be carried out for those systems stating particular interest in this and which have relatively complete and good quality information available. These in-depth studies will complete this guide's case study. One will realise that in-depth research in any case would require the information collected for the outline.

### **b) The chapter “Additional information for good use of the outline ”**

Chapter 4: “Additional information for good use of the outline ” was designed to make the elements introduced in the outline more explicit. To use the outline correctly, it is vital to follow the instructions contained in this part.

In section 4.1 of the guide, a **glossary** is presented. Its use is important even for health insurance specialists. The glossary is not a dictionary of health insurance terms, but a tool to understand the meanings of the terms used in the outline. This acknowledgement is important, as a term, depending on the place and context, may have different meanings and one object may be referred to use using distinctly different terms. Some synonyms have been provided, but of course the list is not exhaustive. The study's authors should use the same terminology used in the outline or indicate the meanings of the terms that they use.

**Explanations of points raised in the outline** are included in section 4.2 of the guide. These explanations clarify the meaning of certain questions included in the outline. An asterisk indicates the points for which there is further clarification. For example, C.53\*.

Part F of the outline deals with the indicators. **The definition of indicators** is presented in section 4.3 of the guide. The authors are not asked to produce these indicators, but to present them when they are available from the insurance system studied. Here, as well, misinterpretation is possible because of the variety of names given to the indicators and the various possible calculation methods. In section 4.3, the calculation formulas of the indicators used in the outline are given to specify their content. The formulas used by the

insurance system to determine the indicators should be presented with their values and the periods (dates) to which they correspond.

### **c) *The sources of information***

Although the points in the outline are often presented as questions, the points covered do not necessarily have to be addressed by posing the exact questions to the insurance system's officials or other people. They can be posed in another way, since the outline is not a questionnaire. The researched information can be obtained from interviews, as well as documentary sources such as:

- internal statutes and rules ;
- minutes from general assemblies or meetings;
- protocol and management manuals;
- forms (membership, claims, etc.) used by the IS;
- accounting and registration of current operation documents (membership, benefits, etc.);
- management boards (notably for the indicators);
- activity and evaluation reports, etc.;
- reports on members' opinion polls;
- information updates for members.

The abundance and the quality of documentary sources vary widely from one system to the next. From the outset, it is important to identify, with the insurance system's officials, the range of documentary sources available. These documents have to be scrutinised thoroughly by the study's authors. This examination should not be conducted after the visit, since any clarifications should be obtained from the IS' members.

Interviews should be prepared by the study's authors. The content, among other things should be determined, according to the documentary information available. It is advisable to crosscheck the information between various sources. Appendix 3 also requires an appreciation of the quality of information.

## **2.2 From the outline to the report**

The case study ends with the production of a report. This report should be structured according to the standard plan presented in appendix 1. This plan is the same as that of the outline (except that it contains an introduction and a conclusion).

Every chapter, section, or subsection of the standard plan corresponds to a chapter, section or sub section in the outline. The outline states the points to be dealt with in each corresponding part of the report. For example, the points explained in sub section 2.1, Part D of the outline, entitled: *"Health Services Covered by the Insurance System"* illustrate the points that should be treated in the sub section of the report, entitled the same.

In the outline, most of the points are presented in a question format. For example, in the above-mentioned sub section, one would find these types of questions: *"if a waiting*

*period is applied, in practice how is it controlled? Are there any exceptions made in its application? In which cases? Who decides?”*

Every chapter, section and sub-section should be presented in the form of a text, and not as a set of responses to the questions included in the outline. Yet, the reader should find the responses to these questions in the text. The tables, which are explained in the outline, should also be completed.

In order to facilitate the analysis of the reports and to prevent difficulties in researching the information, it is imperative that the authors:

- include in the report, all the chapters, sections and sub-sections presented in the standard plan. If one of these elements are not relevant, it should be indicated, in the report, under the corresponding title;
- Add any section or sub-section deemed necessary insofar as the particular characteristics of the insurance system studied, to supplement the information projected by the standard plan;
- Include in the text, all relevant points, which do not require the addition of new sections or sub-sections, but with which the outline has not dealt;
- Complete the control list presented in Appendix 2 to ensure that the various points introduced in the outline have been covered (or indicate the reasons for not covering them).

## **2.3 The guide appreciation record**

With a view to progressively improving the guide, which will be used in other regions of the world, an appreciation card is included in appendix 4. It is desirable that authors complete this card once the report is archived.

## **3. Outline for implementing case studies**

### **3.1 Outline Plan**

#### **A. Synthetic description of the Health Insurance System**

#### **B. The Context in which the Insurance System Operates**

1. Demographic Aspects of the IS' Zone of Operation
2. Economic Aspects
3. Social Aspects

4. Sanitary Indicators
5. National Health Policy
6. Supply of Health Care
7. Social Protection in Health

### **C. The Implementation of the Health Insurance System**

1. The IS' Launch
2. The Phases of the IS' Implementation
  - 2.1 Identifying Needs and Defining Objectives
  - 2.2 Context and Financial Feasibility Studies
  - 2.3 Information on the Target Group
  - 2.4 The Launch of Activities
  - 2.5 Leadership and Decision-making
3. Operation during the First Term
  - 3.1 Members and Other Beneficiaries
  - 3.2 Benefits
  - 3.3 Financing
  - 3.4 Health Care Providers
  - 3.5 Administration and Management
4. Technical Assistance and Training

### **D. The Insurance System's Characteristics**

1. The Target Group and the Beneficiaries
  - 1.1 The Target group
  - 1.2 The various Categories of Beneficiaries
  - 1.3 The Number of Beneficiaries and its Evolution
  - 1.4 Reasons for Losing Membership Status
  - 1.5 The Target Group's Penetration
2. Benefits and Other Services Offered by the Insurance System
  - 2.1 Health Services Covered by the Insurance System
  - 2.2 Benefits Payments

- 2.3 Other Services Provided for Members
- 3. Financial Aspects of the Insurance System's Operation
  - 3.1 IS' Finance Sources
  - 3.2 Costs
  - 3.3 Surplus Allocation
  - 3.4 Reserve Funds
- 4. Health Care Providers
  - 4.1 Health Care Providers Linked to the Insurance System
  - 4.2 The Relationship between the Health Care Providers and the Insurance System
  - 4.3 Payment of Health Care Providers
- 5. The Insurance System's Administration and Management
  - 5.1 Statutes and Regulations
  - 5.2 The IS' Management Organisation
  - 5.3 The Democratic and Co-operative Character of Management
  - 5.4 Financial Management
  - 5.5 The Information System and management tools
  - 5.6 The Function of Control
  - 5.7 Role Distribution
  - 5.8 Equipment and Infrastructure
- 6. Actors in Relation to the Insurance System
  - 6.1 Reinsurance and Guarantee Fund Schemes
  - 6.2 Technical Assistance
  - 6.3 Social Movements and Social Economy Organisations
  - 6.4 Other Actors

**E. The Indicators of the Insurance System's Operation**

- 1. The Membership Dynamic
- 2. Service Use
- 3. Financing and the Financial Situation
- 4. Members' Participation

## **F. The Actors' Points of View vis-à-vis the Insurance System**

1. Evaluation Processes
2. The Officials' Points of View
  - 2.1 The Insurance System's Implementation
  - 2.2 The Membership Dynamic
  - 2.3 Access to Health Services and the Relationship with Health Care Providers
  - 2.4 Contributions Payment
  - 2.5 Determining the Contributions/benefits Relationship
  - 2.6 Insurance Risk-Management
  - 2.7 Fraud
  - 2.8 Administration and Management
  - 2.9 Relationship with the State (federal, national, provincial) and Local Collectives
  - 2.10 General Operation
3. The Beneficiaries' Points of View
4. The Health Care Providers' Points of View
5. The Other Actors' Points of View

## **3.2 Outline**

### **Part A: Synthetic description of the Health Insurance System**

Part A is the framework of the study. As such, it will have to be completed after the development of the other chapters of the study. However, it will have to be placed first in the report, as the standard plan of the report indicates. It will give a synthetic vision of the IS, which will help the reader to understand and analyse the information contained in the remainder of the study. The framework will have to be presented in the same format as that presented here.

A.1 Name of the insurance system (IS): \_\_\_\_\_

A.2\* Name of the IS' parent company or company, which owns it (if the ownership is legally defined): \_\_\_\_\_

- A.3 Address of the IS' headquarters: \_\_\_\_\_
- A.4\* Date IS was created (conception): \_\_\_\_\_
- A.5 Date IS launched operation (payment of first benefits): \_\_\_\_\_
- A.6\* Date IS' parent company was created (if different from the creation date of the IS): \_\_\_\_\_
- A.7 Nature of IS' parent company:
- association
  - mutual
  - co-operative
  - community organisation other than a co-operative or mutual
  - other NGO
  - profit-making health care provider
  - non profit-making health care provider
  - trade union
  - other: specify \_\_\_\_\_
- A.8\* Legal recognition of the IS:
- Yes status \_\_\_\_\_
  - No
- A.9 Other activities of the IS' parent company:
- none
  - death insurance
  - prevention, health education
  - disability insurance
  - savings/ credit
  - pension
  - trade union type activities
  - education/ literacy
  - other forms of insurance:  
specify \_\_\_\_\_
  - other social services  
specify \_\_\_\_\_
  - other activities  
provide a list \_\_\_\_\_
- A.10\* Types of members:

- individuals
- families
- groups

A.11\* Other beneficiaries:

- family
- other dependants
- the poorest
- other: \_\_\_\_\_

A.12\* Acquisition of beneficiary status:

- voluntary
- automatic
- compulsory

A.13 Current number of IS members:

Category /sex	Male	Female	Total
Salaried Staff			
Retired			
Total			

A.14 Current number of IS beneficiaries:

Age /sex	Male	Female	Total
0 – 5 years			
6 – 18 years			
19 – 65 years			
65+ years			
Total			

A.15\* Total current number of members of the IS' parent company:

A.16 Residential location of members:

- rural area                      % \_\_\_\_\_
- urban area                        % \_\_\_\_\_
- suburban area                    % \_\_\_\_\_

A.17 Relationship between members (other than membership to the IS):

- no relationship

- members of the same company
- members of the same professional sector
- members of the same village, district, or geographic community
- members of the same ethnic group
- members of the same co-operative
- members of the same mutual
- members of the same trade union
- members of the same association
- other

A.18\* Economic situation of members:

- \_\_\_\_\_% of members who work in the informal sector (including subsistence agriculture)
- \_\_\_\_\_% of members who work in the formal sector.
- Middle-class income \_\_\_\_\_% of members (\_\_\_\_\_% women)
- Lower middle-class income \_\_\_\_\_% of members (\_\_\_\_\_% women)
- Income under the poverty line \_\_\_\_\_% of members (\_\_\_\_% women)
- Extreme poverty income \_\_\_\_\_% of members

A.19 Restrictions on membership:

- No restriction applied
- Age
- Sex
- Health risks
- Place of residence
- Religion
- Ethnic group or race
- Income
- Non-membership to any particular group (company, co-operative, trade union, etc.)
- Other

A.20\* Geographic area of IS' operation:

- District/village
- Department
- Province/region
- National

A.21 Type of health services covered by the IS:

- Ambulatory care
- Hospital care
- Specialised medicine
- Preventive and promotional care
- Medicines
- Gynae-obstetrical care
- Laboratory examinations

- Radiology
- Vaccinations
- Other: \_\_\_\_\_

A.22 Total amount of benefits paid during the last term (default year)  
 \_\_\_\_\_ (in local currency) for the period \_\_\_\_\_

Equivalent in US \$ \_\_\_\_\_

A.23\*Method of financing the health insurance:

- Members' contributions
- Other contributions
- State contribution to the IS
- Subsidising of health care providers linked to the IS
- Transfer of profits from the IS' parent company's other activities
- Contributions and subsidies from other organisations involved
- Financial returns on the reserves
- Other: \_\_\_\_\_

A.24 Type of contributions:

- Fixed fee using member differentiation by category (age, sex, etc.)
- Fixed fee without member differentiation by category
- Percentage of income with differentiation of members by category
- Percentage of income without differentiation of members by category
- Linked to members' personal risks
- Other \_\_\_\_\_

A.25 Average annual amount of contributions paid by members during the operating year:

Amount (local currency) \_\_\_\_\_ Equivalent in US \$ \_\_\_\_\_

A.26 Health care providers offering services covered by the IS:

- Public sector level \_\_\_\_\_  
number \_\_\_\_\_
- Profit-making private sector level \_\_\_\_\_  
number \_\_\_\_\_
- Non profit-making private sector level \_\_\_\_\_  
number \_\_\_\_\_
- Belonging to the parent company level \_\_\_\_\_ number \_\_\_\_\_

A.27\* Degree of members' participation in management:

- Democratic management by members (general assembly)
- Management by the IS' parent company without members' participation
- Management by parent company with members' participation

A.28\* Who is responsible for the management of current operations:

- No salaried staff
- Unsalaries officials and salaried managers
- Management exclusively by salaried employees of the IS
- Management entrusted to a public  or private  operator
- Participation in managing salaried staff from other organisations

A.29\* Technical assistance:

- Benefits from regular technical assistance since \_\_\_\_\_
- Benefits from periodic technical assistance since \_\_\_\_\_
- Benefits from specific technical assistance since \_\_\_\_\_
- Does not benefit from technical assistance

A.30 Membership to a reinsurance system:

- Yes
- No

A.31 Has guarantee funds:

- Yes
- No

A.32 Other key actors in the operation of the IS:

Actors:

Roles:

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## **Part B: The Context in which the Insurance System Operates**

This part aims to present the IS' context of operation. The data specified indicate the minimum information that must be included in this presentation. For example, in section 1, a description of the demographic framework of the IS is required. This description will have to include the information contained in points B.1 to B.5.

If it is not stated directly, the data should relate to the IS' zone of intervention. Any possible gaps or distinctive features, compared to national data must also be presented. In Part D, information specific to the target group or the beneficiaries is addressed. As far as possible, the evolution of the data during the last years will have to be shown.

The study's authors will be able to apply all practical accuracy, with reference to the data variations within the IS' zone of intervention (for example insofar as the location, the economic sector, etc.). It is possible that information is available for only part of the zone covered by the IS. In this case, this will have to be clearly indicated in the report.

The authors are not asked to "produce " the data (for example, by carrying out surveys) but to use existing information.

Since it is not the main objective of the study, this presentation on the context should not be too long.

### **1. Demographic Aspects of the IS' Zone of Operation**

- B.1 Population size and growth rate – division of the population according to age group and sex.
- B.2 Density (number of people per km<sup>2</sup>)
- B.3 Segment of the population living in urban, suburban and rural areas respectively.
- B.4 Existence of migratory movements
- B.5 Average number of members per family (or household).

### **2. Economic Aspects**

- B.6 Main economic sectors and employment creation sectors of the zone's population.
- B.7 Unemployment and underemployment rates (also present national data).
- B.8\* Percentage of employment in the informal sector and mobility between the informal and formal sectors.
- B.9\* Average income per inhabitant, disparities in income and in minimum wages within the zone (if legally defined).
- B.10 Level of health expenses.

### **3. Social Aspects**

B.13 Level of education and literacy.

B.14\* Accessibility of social services.

B.15 Types of popular traditional organisations of the population. The most representative recent organisations and the proportion of people who are members of at least one organisation.

### **4. Sanitary Indicators**

B.16 Life expectancy, mortality rate, rate of infant and maternal mortality, morbidity rate, main infections and causes of death.

B.17 Cleansing, access to drinking water.

B.18\* Frequency rate of visits to health establishments.

### **5. National Health Policy**

B.19\* What are the broad outlines of the national health policy, particularly insofar as privatising the supply of health care and the sector's financing (including cost recovery) and the role given to the population.

B.20 When was this policy initiated? How applicable is it nowadays? How does the IS fit into this policy?

B.21 Has a particular regulatory system been put in place for the State to control and improve health quality at the local level?

### **6. Supply of Health Care**

B.22 Density of supply: number of doctors, nurses, midwives, hospitals, clinics, health centres and pharmacies per inhabitant.

B.23 Sufficient or insufficient health care services supplied.

B.24 Geographic distribution of the supply of health care: distances between health care providers, zones and work places.

B.25 Proportion of health care providers who belong to the various sectors (public, social security - including special programmes for rural and informal sectors, profit-making or non profit-making private sectors).

### **7. Social Protection in Health**

B.26\* What traditional forms of solidarity exist within the population to cope with health problems? Are these forms of solidarity widespread? Are they increasing or decreasing?

- B.27 Describe briefly the current organisation of the country's social security system. Indicate when this was implemented and if it is being reformed.
- B.28 What are the categories of people, nationally and from the IS' zone of intervention, who cannot benefit from health coverage through the social security system?
- B.29 What are the types of benefits supplied to the main categories of beneficiaries of the social security system? What is the level of contribution required from the beneficiaries (main categories of beneficiaries)?

## Part C: The Implementation of the Health Insurance System

This part is devoted to the description of the IS' creation process and its launching phase. It also illustrates the IS' operation at the end of the first term.

If the IS has been operating for less than one year, section 3 can be omitted. It should be noted that the questions in section 3 are included in the description of the IS' current operation (Part D). For this reason, in some cases, it may be beneficial to pose questions based on a similar point in the past (Part C) and in the present (Part D) in a related way. For section 3, the period commencing the launching date until the end of the first legal term is understood as the first term. If this duration is less than six months, the whole of the first term following the launch of activities will have to be considered.

### 1. The IS' Launch

- C.1 What were the main characteristics of the supply of health care within the IS' zone of operation: density of health care providers, type of providers (profit-making or non profit-making, public, private), levels, availability and quality of services, management autonomy, etc.?
- C.2 What was the national and local policy insofar as financing health services, particularly with regard to cost recovery, at the time when the IS was created?
- C.3\* Specify the following characteristics of the target group at the time the IS was created:
- Size: distribution by age and sex.
  - Education level (including literacy).
  - Residence (including urban/ rural) and geographic spread.
  - Exposure to sanitary conditions and/ or risks of particular diseases.
  - Level of access to health care and social protection.
  - Economic sectors.
  - Income periods and levels, degree of income monetarisation.
  - Membership to a specific structure (community, company, trade union, co-operative, etc.).
  - Ethnic or social ties.
- C.4\* In terms of these socio-economic characteristics, what was the target group's position in relation to the rest of the population in the IS' zone of operation?
- C.5\* What were the target group's main obstacles to access to different types of health care? Were these difficulties common for all members of the target group? Were they increased by a particular policy or event in the period before the IS' creation?
- C.6 From what social protection did the members of the target group benefit? If they benefited from social protection, what motivated the IS' creation? If they did not, indicate the main causes of exclusion from the social protection systems.
- C.7 What was the level of organisation of the target group before the IS' creation? Were there structured organisations with regular activities? Was an organisation

- created to implement the IS or was it linked to a pre-existing organisation? If the latter was the case, was the creation of the IS linked to or influenced by other activities of the organisation? In what way?
- C.8 Before the IS' creation, how was the target group involved in managing the supply of health care and in the overall functioning of the health sector?
- C.9\* Who introduced the idea of the IS and what was the motivation? Did s/he have previous experience in this field? When was this idea introduced? Was it in relation to a programme or particular national policy?

## **2. The Phases of the IS' Implementation**

### **2.1 Identifying Needs and Defining Objectives**

- C.10\* Who conducted the process of identifying the IS' needs and defining its objectives? Over what period did this take place? Was it carried out before or after the IS' launch?
- C.11 Was the target group consulted to identify the needs and define the objectives? In what way? What were their main hopes and fears vis-à-vis the IS' creation?
- C.12 Were the sanitation authorities, local authorities (districts and local councils) or health care providers consulted? In what way and what was their role? What were their main hopes and fears vis-à-vis the IS' creation?
- C.13 Who were the other parties involved in identifying the needs and defining the objectives of the IS? What was their role and attitude?
- C.14 What were the needs identified? Have they been laid out in any document?
- C.15 What were the objectives stated at the outset? Were they documented?

### **2.2 Context and Financial Feasibility Studies**

- C.16\* Was context study of the IS' creation conducted? If so, at what time and by whom? Which were the main aspects studied (attach a copy of the report)? How were the results of the study used?
- C.17 Was a financial feasibility study carried out? If so, by whom? At what time? Were the health care providers involved in carrying out this study? (Attach a copy of the study report if available). Were the results of the study used effectively to choose the benefits and to determine the contributions?
- C.18 If a financial feasibility study has not been carried out, how was the benefits/contributions relationship determined?
- C.19 Was another insurance system visited to facilitate the IS' conception?

### **2.3 Information on the Target Group**

- C.20\* Did the members of the target group have previous experience with insurance systems? Were there other experiences in health insurance within the zone?
- C.21 What were the activities undertaken to inform the target group of the IS' creation, its operation and the interest in their membership? Were informative tools produced? (Attach copies to the report.)
- C.22\* What was the attitude of members of the target group to the IS' creation? Were there any obstacles that delayed membership? Which were they? What actions were taken to overcome them?

### **2.4 The Launch of Activities**

- C.23 Was the establishment of the IS marked by any particular event: a constitutional general assembly, a special meeting of the council of the parent company, etc.? On what date did this event take place? Who participated in this event?
- C.24 Was the IS granted legal status from the outset? What legal status was it granted?
- C.25 On what dates did the first members register, did contribution collections begin and were the first benefits paid?

### **2.5 Leadership and Decision-making**

- C.26 Who assumed responsibility for the IS' creation?
- C.27\* Who assumed the leadership (animation, co-ordination, etc.) in the process of the IS' creation? If a "working group" was formed, indicate what was its composition and how did it operate.
- C.28 With reference to the following, indicate how decisions and/or choices were made (Who made them? On what occasion? Based on votes or consensus? etc.)  
:
- the services covered and the benefits
  - the contributions
  - the conditions of membership and coverage of other beneficiaries
  - the statutes, internal organisation
  - management methods
  - health care providers
  - other (important decisions to be specified)
- C.29 Was external technical assistance sought to facilitate the decision-making process? By whom? (Details concerning technical assistance will be required in section 4.)

### **3. Operation during the first term**

#### **3.1 Members and Other Beneficiaries**

C.30\* Did the IS allow the membership of:

- unaccompanied individuals.
- families (specify composition and number).
- groups (other than family groups).

C.31\* Specify in each case:

- whether membership was voluntary, automatic or compulsory.
- whether service charges were collected (if necessary, indicate the amount)
- whether there were any particular conditions (criteria) prerequisite to membership (membership to an organisation, place of residence, age, sex, etc.). Indicate whether here was any room for negotiation insofar as applying these conditions.

C.32 At the outset members were:

- without any particular ties
- members of the same company. Which one?
- members of the same professional sector. Which one?
- members of the same village or geographic community. Which one?
- members of the same ethnic group. Which one?
- members of the same trade union. Which one?
- members of the same co-operative or mutual. Which one?
- other

C.33 Were these first members representative of the target group or were they part of a sub-group with their own specific characteristics?

C.34\* In addition to the members, what were the IS' other categories of beneficiaries?

- members' families
- members' other dependants
- the poorest
- other

For each of these categories of beneficiaries, indicate the restrictions applied (number of family members, family ties to the member, age, etc.), the prerequisite conditions for receiving the IS' benefits.

C.35 At the end of the first term, how many beneficiaries were there in each category? Was this number different from that envisaged by the initiators of the IS? What were the reasons for this difference?

### 3.2 Benefits

C.36 Following the indications below, complete table no.1:

“Services”: Indicate the type of service covered under the corresponding title.

“Persons Covered”: Write “M” if only members are covered by the service and “B” if other beneficiaries are covered as well. If the conditions for coverage are different for members and other beneficiaries, include two lines - one for the members and one for other beneficiaries. (Or create two tables if the conditions for coverage are different for a significant number of covered services.)

“Co-payment”: Indicate the share of the service price which the beneficiary has to pay. This would be a percentage, if a ticket moderator is used and an amount in the case of a deductible.

“Maximum Coverage Limits”: Indicate the maximum amount or duration (hospitalisation) for reimbursement.

“Waiting Period”: Indicate the length of the waiting period. Write “0” if none exists.

“Compulsory Reference”: Write “C” if the reference is compulsory. This refers to a patient’s need for a referral from a less complex stage in order to benefit from his insurance coverage at a more complex one. Register " N " in the contrary case.

Attach the documents given by the beneficiaries, which describe the benefits, if there are any.

**Table no.1: Services covered by the IS during its first term**

Services	Persons Covered	Co-payment	Maximum Coverage Limits	Waiting Period	Compulsory Reference
<b>Unprogrammed Surgical Interventions</b>					
All					
<b>Gynae-obstetrical Interventions</b>					
All					
<b>Medical Hospitalisation</b>					
All					

<b>Programmed Surgical Interventions</b>					
All					
<b>Programmed Ambulatory Care</b>					
All					
<b>Preventative Care</b>					
<b>Unprogrammed Ambulatory care</b>					
All					
<b>Medicines</b>					
All					
<b>Transportation/Evacuation</b>					
<b>Specialised Medicines</b>					
<b>Laboratory/Radiology</b>					
<b>Other</b>					

C.37 Was there only one benefits package offered, or could each member choose from several benefits categories?

C.38 What are the main factors which determined the choice of benefits (available services, current diseases, existing coverage, members' capacity to contribute, etc.)?

C.39 What method did the IS use to pay the health care providers?

- Direct payment to the health care provider and reimbursement by the IS
- Third-party payment (with or without a ticket moderator)
- Other

C.40 From the outset, was a benefits monitor introduced (average cost of benefit, total number of cases, number of cases/beneficiaries, etc.)?

### 3.3 Financing

C.41 Using table no. 2, specify the resources used to finance the following:

- technical assistance, education and training during the IS' conception phase and during the first term. (This could be described here as methods used. For example, 1 accountant for 2 weeks.)

- infrastructure and equipment obtained during the IS' conception phase of and during its first term.
- management costs and the benefits during the first term.
- the set up, if it occurred, of a preliminary fund.

Indicate "undefined" in the "aim" column for resources with no particular allocation and which can be used for various objects.

**Table no. 2 Resources used to finance the IS' creation and its first term**

Source	Amount (Specify currency)	Aim	Kind (Subsidy, credit, contributions, etc.)

C.42 Present the various types of contributions that the IS implemented during the first term (according to the categories of beneficiaries). For each one, specify:

- the amount to be paid when it is a fixed fee. Indicate if different amounts are fixed by categories of members (age, sex, health status, etc.)
- the percentage used to calculate if it is determined as a fraction of the member's income. Indicate if percentages are fixed by categories (age, sex, state of health, etc.).
- the method of calculating if linked to members' personal risks.
- the payment period and whether or not it can be split. Indicate whether particular conditions were applied to certain categories of members.
- the form of payment (kind, cash).
- the benefits which they guarantee.

Indicate whether contributions were paid by persons (legal or physical) other than the beneficiaries.

C.43 What was the amount of the reserves or of the preliminary funds when benefits were first paid?

### 3.4 Health Care Providers

C.44 At the end of the first term, which were the health care providers offering services covered by the IS?

- Public sector (level and number)
- Profit-making private sector (level and number)
- Non profit-making private sector (level and number)
- Belonging to the IS' parent company (level and number)

C.45 What criteria were used to choose the authorised health care providers? Who decided?

C.46\* What was the billing method used by the authorised health care providers?

- Fixed annual fee
- Case payment
- Fee-for-service
- Per diem fee for hospitalisation
- Other

C.47\* Have any agreements been established with these health care providers? What were the main clauses?

C.47bis Do the health care providers receive any subsidies that affect the price of the services that they offer the IS?

### **3.5 Administration and Management**

#### **a) Statutes and Regulations**

C.48 Did the IS have statutes and/ or internal regulations from its inception? If so, how were they defined and adopted? What were their focal points? (Attach copies to the report.)

C.49 Did the IS have its own juridical status? From when? Originally, what was the name of the IS?

#### **b) Management Organisation**

C.50\* What organisation was responsible for the IS' general management? What other organisations were involved in the insurance's management? What were their responsibilities?

C.51 Was the IS' management independent of that of health services (account separation, particularly if the IS is managed by a health care provider)?

C.52 Give a list of the different management organs operating at the end of the first term. Did these organs belong exclusively to the IS or were they involved in the execution and management of other activities or groups? What was their composition and mandate? How were they implemented?

**Table no. 3: Salaried staff employed by the IS**

<b>Category</b>	<b>Number</b>	<b>Employer</b>	<b>Percentage of time dedicated to the IS</b>

**c) Information System**

C.55\* Which of these documents were introduced from the IS' inception or during its first year of operation:

- members' register
- membership card
- contributions register
- benefits monitor register
- accounting framework documents (provide the list)

C.56 Which of the following have been implemented:

- an accounting system from the first term
- a budget for the first term
- a treasury plan for the first term
- an estimated balance sheet
- other financial management tools (provide a list and details)

**4. Technical Assistance and Training**

C.57 If technical assistance was provided during the creation phase of the IS and during its first year of operation, complete the table below:

**Table no. 4: Technical assistance summary (creation phase and first year of operation)**

<b>Organisations or persons providing technical assistance</b>	<b>Focus of the support provided</b>	<b>Duration (period) of support</b>	<b>Direct beneficiaries of the support</b>

C.58 If any training was undergone during the creation phase of the IS and during the first year of operation, complete the table below:

**Table no. 5: Training (creation phase and first year of operation)**

<b>Organisations or persons implementing training</b>	<b>Training objective</b>	<b>Duration (period)</b>	<b>Direct beneficiaries of the training</b>

## Part D: The Insurance System's Characteristics

Unlike section 3 part C, which illustrates the end of the IS' first term, this part describes its current operation. It is important that the responses to the various questions reflect the gap between what is projected by the law, statutes and other regulations, and what is actually practised.

### 1. Target Group and Beneficiaries

#### 1.1 Target Group

D.1 If the target group is no longer that formerly defined, (see C.3) specify the following characteristics:

- Size: distribution by age and sex.
- Education level (including literacy).
- Residence (including rural/ urban) and geographic spread.
- Exposure to sanitary conditions and/ or risks of particular diseases.
- Level of access to health care and social protection.
- Economic sectors.
- Income periods and levels, degree of income monetarisation.
- Membership to a specific structure (community, company, trade union, co-operative, etc.).
- Ethnic or social ties.

Indicate the causes and main consequences of this evolution of the target group.

D.2\* What categories of people are excluded from the target group?

#### 1.2 Various Categories of Beneficiaries

D.3 Does the IS allow membership of:

- Unaccompanied individuals.
- Families (specify composition and number).
- Groups (other than family).

D.4 Specify in each case:

- whether membership is voluntary, automatic, or compulsory.
- whether service charges are collected or social capital shares paid  
Indicate the amount.
- whether there are any particular conditions (criteria) prerequisite to membership (membership to a particular organisation, place of residence, age, sex, etc.)

Indicate whether there is any possibility of discretion in applying these conditions.

- D.5 What ties are there between members (apart from IS membership)
- without any particular ties
  - members of the same company. Which one?
  - members of the same professional sector. Which one?
  - members of the same village or geographic community. Which one?
  - members of the same ethnic group. Which one?
  - members of the same trade union. Which one?
  - members of the same co-operative or mutual. Which one?
  - Other
- D.6 What are the procedures for obtaining membership? Who receives membership requests? Who ensures that conditions (criteria) are being met? Does the new member have to sign a contract?
- D.7\* Is subscription limited to a designated period? Is it restricted to a particular time of the year?
- D.8 Is there a members' register? Indicate what information it comprises.
- D.9 Are there membership cards? Provide details (or attach a copy of the card to the report). If not, how are members identified?
- D.10 In addition to members, what are the IS' other categories of beneficiaries?
- members' families
  - members' other dependants
  - the poorest
  - other
- D.11 For each of these categories of persons, state what restrictions are applied (for family: maximum number of persons protected, family relationship to the member, maximum age, etc.), and prerequisite conditions for receiving the IS' benefits.
- D.12 At what times do members and other beneficiaries have to present their cards?
- D.13\* Summarise the main changes in the conditions for IS membership since its launch. State the reasons given by the IS' officials for these changes.

### 1.3 The Number of Beneficiaries and its Evolution

D.14\* Complete the following tables:

**Table no.6: Current number of members**

Age/ sex	Male	Female	Total
0 - 5 years			
6 - 18 years			
19 – 65 years			

More than 65 years			
TOTAL			

**Table no.6bis: Current number of beneficiaries**

Age/ sex	Male	Female	Total
0 - 5 years			
6 - 18 years			
19 – 65 years			
More than 65 years			
TOTAL			

**Table no.7: Monitor of members and beneficiaries numbers**

	Year N-2 (distributed by sex and age- group)	Year N-1 (distributed by sex and age- group)	Year N (distributed by sex and age- group)
Total number of contributing members with:			
Voluntary membership			
Automatic membership			
Compulsory membership			
<b>Total number of beneficiaries</b>			

(N.B.: Year N is the last year for which data is available)

If it was marked by any particular event, indicate precisely how the numbers in the two tables have evolved.

D.15 Complete the following table, if the IS' parent company has other businesses and thus other members.

**Table no. 8 IS' membership growth compared to the parent company's**

	Current number of members (distributed by sex and age group)	Growth rate of membership numbers from the end of the IS' first term
IS		
Parent company		

#### 1.4 Reasons for Losing Membership Status

D.16 Provide a list of the factors (age, health status, change of residence, etc.) which could lead to membership loss. Present the procedures applied. Have these factors changed since the IS' launch? For what reasons?

D.17\* Have certain members already been excluded? For what reasons? Who made the decision?

## 1.5 The Target Group's Penetration

- D.18\* What is the current penetration rate of the target group? How has this evolved during the last three years? What projections have been accomplished by the IS' officials?
- D.19 Is increasing the number of members a priority for the IS? What actions have been taken or are being envisaged to attract target group members to join the IS?

## 2. Benefits and Other Services Offered by the Insurance System

### 2.1 Health Services Covered by the Insurance System

- D.20 How was the choice of services covered by the IS made? What elements were considered (available services, most current infections, existing coverage, capacity of members to contribute, etc.)? Who made the decisions in this matter?
- D.21 Is there a document (or other information tool) that gives a detailed definition of the services covered and conditions of coverage? Attach a copy.
- D.22 Following the indications, complete the table below, which addresses the services covered and the level of coverage.

"Services": Indicate the type of service covered under the corresponding title.

"Persons Covered": Write "M" if only members are covered by the service and "B" if other beneficiaries are covered as well. If the conditions for coverage are different for members and other beneficiaries, include two lines - one for the members and one for other for beneficiaries. (Or create two tables, if the conditions for coverage are different for a significant number of covered services.)

"Co-payment": Indicate the share of the service price that the beneficiary has to pay. This would be a percentage, if a ticket moderator is used and an amount in the case of a deductible.

"Maximum Coverage Limits": Indicate the maximum amount or duration (hospitalisation) for reimbursement.

"Waiting Period": Indicate the length of the waiting period. Write "0" if none exists.

“Compulsory Reference”:

Write “C” if the reference is compulsory. This refers to a patient’s need for a referral from a less complex stage in order to benefit from his insurance coverage at a more complex one. Register " N " in the contrary case.

**Table no.9: Services covered by the IS**

Services	Covered Persons	Co-payment	Maximum coverage limits	Waiting period	Compulsory Reference
<b>Unprogrammed Surgical Interventions</b>					
All					
<b>Gynae-obstetrical Interventions</b>					
All					
<b>Medical Hospitalisation</b>					
All					
<b>Programmed Surgical Interventions</b>					
All					
<b>Programmed Ambulatory Care</b>					
All					
<b>Preventative Care</b>					
<b>Unprogrammed Ambulatory Care</b>					
All					
<b>Medicines</b>					
All					
<b>Transportation/Evacuation</b>					
<b>Specialised Medicines</b>					
<b>Laboratory/Radiology</b>					
<b>Other</b>					

D.23 Is there only one benefits package or can each member choose from several benefits categories?

- D.24 How are members informed of the services covered by the IS and of the possible choices among several benefits categories?
- D.25\* Using an average of corresponding contributions, can all IS' members be insured for the same services? If not, indicate the reasons (residence, criteria applied by the IS: age, sex, health status, etc.) for differential access and how is this demonstrated.
- D.26 What reasons do the officials give to justify co-payments? How are these determined? Are there exceptions in their application? In what cases? Who decides?
- D.27 If a waiting period is applied, in practice, how is it controlled? Are there any exceptions made in its application? In which cases? Who decides?
- D.28 If a reference system is used, indicate the operation methods. Indicate specifically who decides to refer the patient to a more complex level and how the IS is implicated in this.
- D.29 Must beneficiaries assume some level of accountability for indirect costs (transport, food, lodging, etc.) so that they can be treated?
- D.30 Is a medical control sometimes undergone to decide beneficiaries' coverage? Who carries it out?
- D.31 Is management allowed to intervene in deciding beneficiaries' coverage? Specify the cases where this occurs and the methods used.
- D.32 Indicate the five services covered most frequently during the last three terms, as well as the share (number and amount) of the total benefits that each represents.
- D.33 What are the main changes in the service coverage (type of services, level of coverage) since the IS' launch? What are the reasons for these changes? How were they decided? Have they translated into changes in the amount and/ or method of members' contributions?

## **2.2 Benefits Payments**

- D.34 What method does the IS use to pay the health care providers?
- Direct payment to the health care provider and reimbursement by the IS
  - Third-party payment (with or without a ticket moderator)
  - Other
- D.35 Do the forms of payment vary according to the types of services covered?
- D.36 If beneficiary has to pay the health care provider before being reimbursed, is it possible to get advances for large expenses? Describe what conditions apply.

- D.37 What is the procedure for dealing with reimbursement or the supply of health care claims? Who controls the claimant's rights to the benefits and how is it done?
- D.38 How are the health care providers' bills controlled?
- D.39 What happens when the member's contributions are not up-to-date? Do decisions made in practice conform to what is specified in the statutes and regulations?
- D.40 What proportion of claims are rejected? What are the main causes of rejection?
- D.41 What is the average time taken for reimbursement after a benefits claim is made? How is member reimbursement actually applied?
- D.42 Is there a document where benefits provided can be indexed (number, amount, average cost) by service types? Describe the document.
- D.43 Are claims more significant proportionally among a particular sub group of members (for example rural, urban)?

## **2.3 Other Services Provided for Members**

### ***a) Other Financial Health Services***

- D.44 Does the IS or its parent company offer members a health credit system for services not covered or for co-payments? What is the total number and amount of health credits for the last three years?
- D.45 What are the conditions (eligibility, amount, rate, duration, etc.) for granting this credit? What is the recovery rate? Against what funds is it given? Is it managed by those who manage the IS' funds?
- D.46 Does the IS or its parent company offer members a health savings system? In what form? How has the number and volume of members using the health savings system evolved during the last three years? How are the health savings funds invested? Are they managed by those who manage the IS' funds?
- D.47 Are members offered other types of financial health services? Indicate whether the IS intends to develop such services or, on the contrary, present the reasons for their disappearance.

### ***b) Health Supply***

- D.48 Does the IS or its parent company offer direct medical services (the supply of health care)? What are these services? What criteria are used to choose these services? Who chooses?
- D.49 Were these services created before, after, or together with the IS?

- D.50 Are these services intended exclusively for the IS' beneficiaries? For whom else are they intended? Are there differences in access conditions for the IS' beneficiaries and for others who use the services?
- D.51 How was the services' implementation financed? How are the services financed nowadays?
- D.52 Was a legally independent body created to manage this medical service supply? What role do the IS' members play in this management?

**c) *Prevention and Health Education***

- D.53\* Does the IS organise or promote prevention and/ or health education activities? Provide a list of the main activities carried out in this vein in the last years.
- D.54 How is the object or theme of these activities chosen? Are they linked to services covered by the IS'?
- D.55 Are these activities limited to the IS' beneficiaries or to some of them, or do they affect the range of the zone's population?
- D.56 Has the IS organised other activities for the benefit of certain groups of the population for example, the aged or handicapped?

**d) *Other Services***

- D.57 What other services does the IS' parent company offer its members (specify the year that the service was launched)?
- invalidity insurance
  - pension
  - death insurance
  - other forms of insurance (specify)
  - savings/credit
  - trade union-type activities
  - education/literacy
  - other activities

Specify the relative importance with reference to the budget and the number of beneficiaries.

- D.58\* What is the relationship between these services, the IS' membership dynamic and the IS' operation?

### **3. Financial Aspects of the Insurance System's Operation**

#### **3.1 The IS' Finance Sources<sup>2</sup>**

##### **a) Contributions**

D.59 Present the various types of members' contributions (according to members' categories) existent in the IS. For each one specify:

- The amount to be paid when it is a fixed fee. Indicate if different amounts are fixed by categories of members (age, sex, health status, etc.)
- The percentage used to calculate if it is determined as a fraction of the member's income. Indicate if percentages are arranged by categories (age, sex, state of health, etc.).
- The method of calculating if linked to members' personal risks.
- The payment period and whether or not it can be split. Indicate whether particular conditions were applied to certain categories of members.
- The form of payment (kind, cash).

D.60\* If contributions are fixed according to the member's income, indicate how and by whom this is determined or evaluated.

D.61\* If contributions are defined for groups of people, present the methods of calculating these contributions, their average values (in relation to the services covered), the payment conditions (split or single payments, frequency, cash or kind, etc.).

D.62 What kind of contributions do non-member beneficiaries (particularly family) have to make to have access to the benefits?

D.63\* Are some beneficiaries exempted from contributions payments? In what cases? Who decides? Is this type of exemption frequent (number of cases)?

D.64\* If contributions are paid by persons (legal or physical) other than the beneficiaries, state how they are determined and paid?

D.65 How is the actual amount for each type of contribution determined and by whom?

D.66 Can members' contributions be:

- paid in kind
- paid in cash
- paid by standing order from the member's bank account
- paid into a bank account by the member's employer
- paid by an organisation on the member's behalf

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<sup>2</sup> Here only the resources from the IS' members, from third parties or from transfers from its parent company's other activities are taken into account. The IS' other finances sources, particularly its self-financing capacity (the financial resources generated by its activities) are not considered. The relative elements of the IS' financial stability are dealt with in Part E.

- other (specify)

- D.67\* To whom are contributions paid?
- D.68 If contributions are not paid by standing order, does the IS arrange its collection? Indicate collection methods and costs.
- D.69 At what time of the year (or with what regularity) do members have to pay their contributions? Does this period (or regularity) coincide with income payments? If not, what were the reasons for choosing this payment period (or regularity)?
- D.70 Is the member given a receipt for contributions made? Are other documents used to register this payment? Give a description, or attach copies to the report.
- D.71 In case of late contributions payments, does the IS remind members? Describe the procedure followed.
- D.72 Complete the table below for the budgeted contributions of the last three terms.

**Table no.10: Total amount of Budgeted Contributions**

Origin	Amount		
	Term N-2	Term N-1	Term N
Budgeted contributions: members/ beneficiaries			
Budgeted contributions from sources other than members/ beneficiaries (Employers, etc.)			

- D.73 Are contribution amounts regularly revised? By whom and based on what information?
- D.74 What are the main changes in the calculation method used and the contributions amount since the IS' launch? What are the reasons for these changes? How were they decided? Have they resulted in changes in the benefits offered by the IS?

**b) Service charges, Social Capital Shares**

- D.75 Do new applicants have to pay service charges? Do other beneficiaries also have to pay charges (additional service charges, entry charges, registration charges, etc.)?
- D.76 How much are these charges (for the different categories of beneficiaries if they differ)? When do they have to be paid by the beneficiaries?
- D.77 Have there been any changes in these charges since the IS' launch? Are any changes foreseen?

- D.78 Do new members have to buy social capital shares? How are these determined (fixed fee, proportionate to income, etc.)? When do they have to be paid? How much time does it take to reimburse the member when membership is terminated?
- D.79 Since the IS' launch have there been any changes regarding the social capital shares? Are any changes in the calculation methods foreseen?

**c) *The Financial Contribution of the State and Local Collectives***

- D.80 Have the State and/ or local collectives made any financial contributions during the last three terms? If so, indicate:
- their amount and specify how it was determined;
  - whether they are intended for a specific purpose;
  - whether they are exceptional or regular contributions;
  - whether their payment is linked to legislation, national policy or a particular project;
  - the eventual conditions to which their payment is subjected;
  - the starting date for this support and the foreseen duration of the support;
  - whether the State gives the same kind of support to other IS in the country.

D.81\* Have other types of State contributions been made during the IS' existence? How much were they (or their value for example, in the case of transfer assets), in what periods were they given, their purpose or the reasons for their donation.

**d) *Donations and Subsidies from other Sources***

- D.82\* Were gifts or subsidies granted to the IS after its first year of operation? If so, indicate:
- their amount, source and the period in which they were given;
  - whether they were intended for a specific purpose, whether they were linked to a technical co-operation project;
  - the conditions under which they were made;
  - whether the donation of other gifts and subsidies is envisaged in the future.

**e) *Loans and Credits***

- D.83 Did the IS receive any medium-term loans after its first year of operation? What was the purpose? Which were the loan agencies? What were the amounts and the conditions? How was reimbursement carried out or planned?
- D.84 Were any short-term credits used during the last three terms? Is this the IS' normal practice? If so, for what reasons is this credit necessary and how is it reimbursed? If not, for what reasons was it necessary during the term mentioned? How do the IS' officials ensure its reimbursement?

**f) *Transfer Funds from the IS' Parent Company***

- D.85\* Is the IS' financing clearly distinctive (accounting, treasury, management) from its parent company's other activities? If not, are such changes foreseen?
- D.86 Has the parent company transferred any funds to the IS? What was the amount? For what period? In what form (capital, donations, loans, etc.) and under what conditions? For what reasons?

**g) *Other***

- D.87 Present the IS' other significant finance sources.

**3.2 *Costs***

- D.88\* What was the amount of benefits paid out during the first three terms (if possible, indicate by type of benefit)?
- D.89 Are management costs calculated? How much were they for the last three terms? What were their most important elements?
- D.90\* What are the IS' other operation costs (promotion, training, solidarity funds, etc.)?

**3.3 *Surplus Allocation***

- D.91\* Is the IS' legally defined as a profit, or non-profit organisation?
- D.92 What are the possible ways of allocating the IS' surplus?
- distribution among members maximum percentage \_\_\_\_\_
  - increase in contingent reserves legal minimum percentage \_\_\_\_\_
  - transferring the balance to a new account
  - other
- D.93\* What was the IS' surplus (or deficit) during the last three terms? How was it allocated (or financed)?

**3.4 *Reserve Funds***

- D.94 Does the IS have a reserve funds? How much was it at the closure of the last term?
- D.95 How many months of operation does the reserve cover? Are there any legal obligations in this regard? Does the IS always observe the latter?
- D.96 Are these reserves used or invested in any particular way? Are there any legal obligations in this regard? Does the IS always observe the latter?

## 4. Health Care Providers

### 4.1 Health Care Providers Linked to the Insurance System

D.97 Can beneficiaries use any health care provider or must they use those stipulated by the IS (authorised providers)? How does the IS inform its beneficiaries of the health care providers whom they can use to take advantage of their benefits?

D.98\* Complete the table below:

**Table no. 11: The IS' authorised providers**

Name/ Health care Providers' Identification	Type	Level	Type of services offered	Authorisation date

For public health care providers, indicate the organisation responsible for its management (federal state, council, etc.)

D.99 In the IS' intervention zone(s), are there other health care providers at the same level (estimation of the number)? Do certain health care providers have a monopoly of the IS' members?

D.100 What criteria did the IS use to choose the authorised providers? Who made the choice?

D.101 Are the authorised providers free to sign contracts with the IS and change their prices?

D.102 Is the quality of care given by the health care providers controlled? By whom and using what approach (type of control, standards, classification, etc.)? What other controls do sanitation and administrative authorities place on health care providers?

D.103\* Are there problems with the availability of any of the IS' covered services? What measures are taken to reduce these problems?

### 4.2 The Relationship between Health Care Providers and the Insurance System

D.104 Is there a verbal or formal agreement between the IS and the health care providers? Who is responsible for negotiating agreements with the health care providers?

D.105 Are there any conventions that lay out the terms of this agreement (attach a copy to the report)? What is included in these agreements? Do the authorised

providers make any special concessions for the IS and its members? Indicate precisely the accepted advantages insofar as tariffs and service-quality, (“medical” quality, but also reception, delay, etc.) and how they were established.

- D.106 Has the IS ever withdrawn its agreement with a health care provider? For what reason? Who made the decision?
- D.107\* Do the health care providers control the insured person’s right to the benefits?
- D.108 Does the IS have mechanisms or host activities to gather the beneficiaries’ opinions insofar as service quality?
- D.109 Are regular meetings between health care providers and the IS held? What is the purpose?
- D.110\* Do the IS’ beneficiaries or officials participate in the management of authorised medical training? In what way?
- D.111 How has this participation evolved in the last years? Are any measures foreseen in this regard?
- D.112 Have any incentives (allowances, training, etc.) been offered to medical personnel through the agreements between the IS and the health care providers?

### **4.3 Payment of Health Care Providers**

- D.113 What billing method do the health care providers use:
- fixed annual fee
  - case payment
  - fee-for-service
  - per diem fee for hospitalisation
  - other
- D.114\* Has this billing method changed during the last years? For what reasons? Does the IS have a defined policy in this regard?
- D.114bis Do the health care providers receive subsidies which influence the tariffs offered to the IS?
- D.115 Who controls health care providers’ billing?
- D.116 What procedure is used to pay health care providers?
- D.117 What is the average time taken to pay health care providers? Are there significant differences according to the health care providers, the period of the year, etc.?

## **5. The Insurance System's Administration and Management**

### **5.1 Statutes and Regulations**

- D.118 Does the IS have a legal status? Which is it and from what date? How was it defined and adopted? If it does not, for what reasons? What conditions have to be met to obtain legal recognition?
- D.119 What are the tax and control provisions, related to this legal status? Are these provisions really applied?
- D.120 Does the IS have any statutes? From when? How were they defined and adopted? What are the main points? Attach copies to the report.
- D.121 Does the IS have internal regulations? From when? How was it defined and adopted? What are the main points? Attach copies to the report.

### **5.2 The IS' Management Organisation**

- D.122\* What organisation is responsible for the IS' general management? What other organisations are implicated in the insurance's management? What are their responsibilities and relationships?
- D.123 Is the IS' management independent of that of the health service (particularly account separation if a health care provider is responsible for the IS)?
- D.124\* Do several units comprise the IS? What are the functions of and relationships between these units? How many of the units are operational? Where are they located?
- D.125 Provide a list of the IS' administrative and management agents. Do these agents operate exclusively for the IS or are they also engaged in the execution and management of other activities or organisations? Specify the composition, function and authority of each one. Attach an organisation chart, if one is available.
- D.126 How and by whom are the officials of the different agents chosen? What allowance do the statutes and regulations give for renewing officials? Are these observed?
- D.127 What is the current proportion of women among members of the various agents?
- D.128 Complete the table below, which concerns the IS' salaried employees (indicate whether a job description? exists)

**Table no. 12: Personnel (salaried and unsalaried) employed by the IS**

Job title	Salaried or volunteer	Creation date of post	Current title holder's qualification	Main tasks

D.129 Complete the table below, which refers to contributions to the IS' operation made by salaried staff not employed by the IS.

**Table no. 13: Other salaried staff: not employed by the IS or volunteer**

Function	Number	Organisation responsible	Percentage of working time dedicated to the IS	Main tasks

D.130 Which of the IS' unsalaried management officials are compensated for their functions? In what way, since when and by whom?

### **5.3 The Democratic and Co-operative Character of Management**

D.131 At the time of subscription, how does the IS inform new members of their rights and obligations?

D.132\* What information do members receive about the IS' operation? What aids are used (attach copies to the report)? How often is this information provided and by whom? Describe the efforts undertaken to make this information easily accessible to members.

D.133 What is the role (envisaged in the statutes and real) of members in:

- the choice of services covered
- the amount of contributions
- the contribution payment methods
- the choice of health care providers
- the surplus allocation
- the choice of officials
- evaluating the IS' operation

D.134 Are the general assemblies, stipulated in the statutes held? What is the members' level of participation?

D.135 Has the IS implemented a particular strategy to process members' claims and requests for information? If this is not the case, how are these types of requests handled?

## **5.4 Financial Management**

- D.136 Who authorises current expenses?
- D.137 Does the IS have one or several bank accounts? Who is the signing authority for cheques and withdrawals? How far from the IS' headquarters is the closest bank?
- D.138 What is the proportion of cash transactions?
- D.139 Who manages the petty cash? For what is this used?

## **5.5 The Information System and Management Tools**

### **a) Accounting Framework**

- D.140 Does the IS use any accounting framework documents? Are they up-to-date?
- D.141 Are the accounting framework documents in use standardized in concurrence with national legislation? Provide a list (attach copies of the forms used).
- D.142 Who ensures that the documents are up-to-date? What is the person's level of training and what qualifications do they hold? Was particular training undergone to perform this role?

### **b) Information about Members, Contributions and Benefits**

- D.143 Indicate which of these documents the IS uses and whether they are up-to-date:
- members' register
  - membership card
  - contributions register
  - benefits monitor register
  - other documents used to monitor membership, contributions and benefits (provide a list and explain)

### **c) Management Tools**

- D.144 Are any of the following done regularly (specify period):
- a budget
  - a treasury plan
  - an income and expenditure statement
  - a balance sheet
  - operation indicators
  - other financial management tools (provide a list and specify)

D.145 If they are available in summarised format, attach copies of the income and expenditure statement and the balance sheet for the last three terms.

D.146 Can the IS' information system make available immediately, or within a reasonable time, information on:

- treasury conditions
- the development of benefits
- contributions recovery
- the situation of the financial investments
- the membership dynamic (new members and terminations)
- managements costs

D.147 Which operations and registrations are computerised?

D.148 Are activity reports written up? How often?

**d) Formalising Management Procedures**

D.149 Provide a list and specify the forms used for the IS' current operation (membership requests, contracts, reimbursement claims, benefits payments, etc.)

**5.6 The Function of Control**

D.150 Summarise the methods of internal control used:

- petty cash control
- accounting control
- beneficiary status control
- contributions payment control
- control of the rights to benefits
- control of health care providers billing
- medical control
- other (specify)

D.151 Specify whether these controls are regular and describe how they are applied (or refer to the sections where these are described).

D.152\* What are the external controls to which the IS is subjected voluntarily or by obligation? Who finances this type of regulation?

**5.7 Role Distribution**

D.153 Table no. 14 summarises the IS' role distribution. Complete it using the indications below:

It should demonstrate the actual roles exercised at the time of the case study (and not what was projected by the statutes and internal regulation).

Six categories of actors have been identified:

- The IS' organs: general assembly, council, etc.
- The name (or abbreviation) of the given agent should be written in the corresponding column
- The IS' salaried staff
- Health care providers
- Regular technical assistance staff
- External health care providers (accountant, auditor, etc.)
- Other

Add other columns to include other types of actors, if necessary.

**Table no. 14: Real role distribution**

	The IS' Organs	The IS' Salaried staff	Health care Providers	Technical Assistance staff	External health care Providers	Other
<b>Benefits management</b>						
Who decides the services covered?						
Who makes decisions about coverage?						
Who decides patient referral to a more complex level?						
Who processes claims?						
Who monitors benefits (frequency per covered service, average cost, etc.)?						
<b>Membership management and contributions collection</b>						
Who receives membership requests?						
Who updates the members' register?						
Who initiated membership cards?						
Who decides the exclusion of members?						
Who calculates the contributions amount?						
Who decides the contributions amount?						
Who collects contributions?						
Who carries out contributions recovery?						
Who keeps the contributions register?						

	The IS' Organs	The IS' Salaried staff	Health care Providers	Technical Assistance staff	External health care Providers	Other
<b>Management of relationships with health care providers</b>						
Who chooses the health care providers?						
Who negotiates agreements with the health care providers?						
Who withdraws the agreement with a health care provider?						
Who decides health care providers' payments?						
<b>Accounting and financial management</b>						
Who implements the accounting framework?						
Who prepares the budget?						
Who implements the treasury plan?						
Who works out the income and expenditure statement?						
Who prepares the balance sheet?						
Who calculates the financial ratios?						
Who proposes surplus allocation?						
Who determines surplus allocation?						
Who monitors deposits						
Who recovers debts?						
Who determines the financial investments?						
Who authorises expenditure?						
Who manages the petty cash?						
<b>Control</b>						
Who controls the petty cash?						
Who implements accounting and financial controls?						
Who controls the beneficiaries' status?						
Who controls contributions payments?						
Who controls beneficiaries' rights to benefits?						

	The IS' Organs	The IS' Salaried staff	Health care Providers	Technical Assistance staff	External health care Providers	Other
Who controls the health care providers' billing?						
Who carries out the medical control?						
Who sanctions fraud?						
Who intervenes in embezzlement cases?						
<b>Relationship with the beneficiaries and target group</b>						
Who decides to call a general assembly?						
Who organises the general assembly?						
Who designates officials?						
Who informs beneficiaries of services covered?						
Who organises information campaigns for the target group?						
Who organises prevention and health education activities?						
Who carries out prevention and health education activities?						

- D.154 How was the division of roles presented in the above table determined? Was any particular experience used as a model?
- D.155 What are the main changes in the distribution of roles since the IS' launch? Are there any projected changes?
- D.156 Complete the table below, which deals with the officials and general staff training.

**Table no. 15: Main training of officials and personnel**

Direct beneficiaries of training	Training Objective	Duration (period) of training	Organisations or persons giving training	Financing

## **5.8 Equipment and Infrastructure**

- D.157 Does the IS' parent company have premises? Give a brief description (including decentralised offices): area, size, ownership/ location, etc. Are these premises used exclusively by the IS?
- D.158 Give a brief description of the computer hardware (number and types, internal network) and software (programmes) used.
- D.159 Which communication media does the IS have available (telephone, fax, email, telex)?
- D.160 Apart from this, what equipment does the IS have available (vehicles, photocopy machines, video, etc.)?

## **6. Actors in Relation to the Insurance System**

### **6.1 Reinsurance and Guarantee Funds Schemes**

### **6.2 Technical Assistance**

- D.163 Does the IS receive (has it received) technical assistance? Which organisation provides this?
- D.164 For how long has the IS received this technical assistance? When should it end? Is this assistance given continuously, periodically, or is it specific?
- D.165 What kind of technical assistance is given? What role does technical assistance play in the IS' management? Are any transfers of responsibilities between the IS and the organisation providing technical assistance programmed? During what period?

Answer the same questions if technical assistance was provided in the past. Specify the dates.

### **6.3 Social Movements and Social Economy Organisations**

- D.166 Has the IS established links with any trade unions? When and with what aim? What categories of workers are trade union members?
- D.167 Is the IS a member of any federal (co-operative, associative, or mutual) organisations? For how long has it been a member? Who decided to affiliate?
- D.168 What services are provided by these federal organisations? Does the IS play an important role in their management?
- D.169 Apart from this affiliation, has the IS established relationships with co-operatives, associations, or mutuals? At what time and for what reasons?

## **6.4 Other Actors**

- D.170 What is the relationship between the IS and other actors, such as the social security system, the State or local collectives?

## **Part E: The Indicators of the Insurance System's operation**

As indicated in the introduction to the guide, the case study's objective is not to analyse the efficiency and the viability of the systems. Nevertheless, it is interesting to provide when they exist, the indicators of the insurance system's operation established by the IS. If the data is immediately available, the consultants can calculate these indicators. They are not required however, to reconstitute the data necessary to produce the indicators. Consequently, when these are not available, the indicators will not be presented.

### **1. The Membership Dynamic**

- E.1 Target group's penetration rate
- E.2 Proportion of members who do not belong to the target group
- E.3 Growth rate of the number of members
- E.4 Re-contribution rate (or discontinuation rate)
- E.5 Growth rate unrelated to geographic extension
- E.6 Growth rate linked to geographic extension
- E.7 Number of beneficiaries per member

### **2. Service Use**

- E.8 Consumption rate of covered health services
- E.9 Health services consumption rate of beneficiaries to non-beneficiaries
- E.10 Exclusion rate from covered health services
- E.11 Evolution of the average amount of benefits per beneficiary
- E.12 Average cost of services for the beneficiaries and non-beneficiaries

### **3. Financing and the Financial Situation**

- E.13 Surplus (deficits)
- E.14 Total amount of benefits
- E.15 Contributions recovery rate
- E.16 Percentage of members whose contributions are current
- E.17 Immediate liquidation ratio
- E.18 Solvency ratio
- E.19 Budgeted contributions/ term expenditure ratio
- E.20  $[\text{Budgeted contributions} + \text{regular contributions}] / \text{term expenditure ratio}$
- E.21  $\text{Management costs} / [\text{Budgeted contributions} + \text{regular contributions}] \text{ ratio}$
- E.22 Ratio of benefits coverage by reserves
- E.23 Benefits/ budgeted contributions ratio
- E.24 Rate of internal financing
- E.25 Payment period of health care providers
- E.26 Beneficiaries' Reimbursement Period

### **4. Members' Participation**

- E.27 Frequency of general assemblies/ reunions
- E.28 Frequency of members' opinion polls
- E.29 Participation rate at general assemblies or meetings

## E.29 Participation rate in elections

## **Part F: The Actors' Points of View vis-à-vis the Insurance System**

The aim of the case studies, as shown in the introduction, is not to implement an evaluation of insurance systems. However, the opinions of the actors implicated in the operation of the IS, remains interesting. If different points of view are uncovered within the same group of actors, they must be presented.

The opinions of members will be presented only if the information was collected beforehand and in a systematic manner by the IS using public opinion polls (obviously not organised for this study).

It would be interesting to provide the opinions of health care providers if they all (or a large proportion of them) have been met by the study's writers. If this is not the case, then their opinions will not be presented. However, a meeting between the health care providers and the writers, should be interesting for the latter, because it will improve their understanding of the IS' operation and allow them to verify information.

### **1. Evaluation Processes**

- F.1 Are surveys, meetings and other methods used to obtain information on beneficiaries' opinions insofar as the IS' operation? How often? What are the subjects tackled? What proportion of members is affected?
- F.2\* Are there periodic internal evaluations (auto-evaluation)? Who is responsible for their preparation and execution?
- F.3 What were the main aspects dealt with in these evaluations? Who analyses the results? To whom is this information distributed?
- F.4 Are the members involved in these evaluations? To some extent, is the latter announced or carried out in general assemblies? Have any particular measures been developed to make the information used or produced by the evaluation more accessible to members?
- F.5\* Have there been any external evaluations of the IS? By whom? For what reasons? Who financed them?
- F.6 If any evaluations have been carried out during the last three terms summarise their findings (or attach copies of existing summaries, minutes, etc.).
- F.7 Following the evaluations, have any concrete measures been adopted?

### **2. The Officials' Points of View**

Using the factors below, find the IS' officials' points of view. Do not provide your opinion, which will be left for the conclusion of the report. In this section, more than elsewhere, it is important to adapt and complete the questions, according to the specific situation of the IS.

## **2.1 The IS' Implementation**

- F.8 During the IS' implementation process, which were the main factors that led to its success?
- F.9 What were the main difficulties faced? What could be done to prevent or avoid them?
- F.10 During the years, has there been any change in the attitudes of the various actors involved from the outset? What are the reasons for these changes?

## **2.2 The Membership Dynamic**

- F.11 At present, how much do the beneficiaries and other members of the target group know about the operation of the IS? Is the insurance mechanism well understood and accepted?
- F.12 Within the target group, what are the factors that limit membership? If these factors, in part, exist because of the operation methods adopted why are these not modified? What are the proven fears or reservations concerning the IS? Is a change of the target group projected?
- F.13 For what reasons do some people not renew their membership?
- F.14 What are the main causes of satisfaction and dissatisfaction among the members? Have any steps been taken to reduce the latter?

## **2.3 Access to Health Services and the Relationship with Health Care Providers**

- F.15 Was the IS able to improve the access to health services for its beneficiaries? What factors or indicators demonstrate this? Have any particular measures been taken in this area?
- F.16 To what extent are the benefits offered consistent with the main health needs of the beneficiaries?
- F.17 Does the coverage of members whose payment contributions are not current, constitute a serious problem for the IS' operation?
- F.18 Is there an obvious interest in health education and prevention activities shown by the IS and the beneficiaries? How could this be reinforced?
- F.19 Has the quality of health services improved because of the IS? How is this improvement translated and how can it be measured?
- F.20 Are there any problems accessing the services covered? What is the cause of this? What steps have been taken to reduce this and by whom?

- F.21 Would the IS like to change the health care providers' billing method (fee-for-service, capitation, etc.)? What are the difficulties in producing this change?
- F.22 Are the health care providers' invoices often disputed by the IS? Will the tendency for this type of problem decrease?
- F.23 What is the IS' power of negotiation in dealing with the health care providers? How has this power evolved through the years?
- F.24 Apart from the above-mentioned, what other significant difficulties are there in dealing with the health care providers?

## **2.4 Contributions Payment**

- F.25 What factors explain the delay in contributions? If these factors have been partly created by the adoption of certain operation methods, why are these not changed?
- F.26 What measures have already been taken to reduce the delay in contributions? Are there any other measures planned to address this?

## **2.5 Determining the Contributions/ Benefits Relationship**

- F.27 Is the level of contributions appropriate to the benefits supplied by the IS? What are the main difficulties in verifying that the level of contributions is adequate in relation to the benefits offered and in adapting it in the contrary situation? How are these difficulties overcome?

## **2.6 Insurance Risk-Management**

- F.28 What operation methods and measures were adopted to limit adverse selection? How has this evolved since the launch of activities? Is it at present a serious problem for the IS? What (new) measures are being considered to reduce it?
- F.29 What operation methods and measures were adopted to reduce moral hazard? What role does social control play in this? How has moral hazard evolved since the IS' launch of activities? Is it now a serious problem for the IS? What are the (new) measures being considered to reduce it?
- F.30 What operation methods and measures have been adopted to reduce the risk of cost explosion? How has this risk evolved since the launch of activities? Is it now, a serious problem for the IS? What (new) methods are being considered to reduce it?
- F.31 Does the IS have any financial protection other than its own reserve funds? If not, why is the IS not member of a reinsurance or guarantee fund system?

## **2.7 Fraud**

- F.32 What kinds of fraud does the IS encounter among health care providers and beneficiaries as well as within management?
- F.33 Are there many cases of fraud? How have they evolved since the IS' launch of activities?
- F.34 What measures have been taken to reduce them? What role does social control play in this? How can the current level of fraud be explained? Have any new measures been projected?

## **2.8 Administration and Management**

- F.35 How satisfactory is the IS' legal status? Are there any problems in applying the corresponding legislation? Are changes desirable?
- F.36 Are the organisations responsible for managing the insurance (a private insurer, for example) working in conformity with the IS' expectations?
- F.37 Is the relationship between the IS' headquarters and the various decentralised management units, satisfactory? What are the problems encountered? What methods are being considered or are to be taken to improve the relationship?
- F.38 Is the level of member participation in management satisfactory? What are the main areas in which members should be consulted more?
- F.39 Are there problems with personnel or officials' competence insofar as executing their task?
- F.40 Does the existing information system really correspond to needs? What improvements can be made?
- F.41 What are advantages and inconveniences of periodic renewal of officials? What can be done to reduce those difficulties?
- F.42 Is the level of operating costs satisfactory? What actions can be taken to reduce it?

## **2.9 Relationship with the State (federal, national, provincial) and Local Collectives**

- F.43 Do the State's structures, or that of local communities interfere with the IS' operation? In what way? Is the tendency, for this interference to increase or to decrease?
- F.44 What kind of support would the IS like to receive from the State (and from the decentralised units) and from local collectives? Have discussions on the subject already taken place? What was the result?

## **2.10 General Operation**

- F.45 What new services are being considered by IS' parent company? For what reasons? Are these services linked to the IS, or will they influence it?
- F.46 In what way is the IS' current situation and development linked to other activities of its parent company?
- F.47 Currently, what are the IS' main advantages?
- F.48 What factors limit its efficacy or endanger its viability?
- F.49 What are the main trends to be adopted to improve the IS' operation and impact?

## **3. The beneficiaries' points of view**

As stated above, the beneficiaries' points of view are only to be presented if they were obtained by the IS, beforehand, in a systematic way, using public opinion polls. On the assumption that these surveys would have been defined and completed outside of this case study, the list of points presented here is only indicative.

- F.50 The IS' effect on the health status of its beneficiaries. The comparison of the situation before the IS' creation with that of the target group's members who are not beneficiaries.
- F.51 The adequacy of covered health services to respond to beneficiaries' main needs.
- F.52 The level of contributions.
- F.53 Other advantages secured through the IS.
- F.54 How much is known about the operation rules, particularly insofar as conditions of membership, services covered and benefits?
- F.55 Beneficiaries level of information and consultation on the IS' operation. The changes desired.
- F.56 The level of satisfaction with the health care providers. The problems encountered. The trends experienced since the IS' creation.
- F.57 The level of satisfaction regarding procedures and delivery of benefits reimbursement.
- F.58 Other problems. The changes to be made in the IS' operation.

#### **4. The Health Care Providers' Points of View**

- F.59 The IS' impact on its beneficiaries' health. Any clear differences between the beneficiaries and the rest of the population.
- F.60 The IS' effect on the its beneficiaries' perception of health problems. Behavioural changes.
- F.61 The IS' effective financial and professional support for the health care providers (a share in their turn-over, reducing debts, etc.).
- F.62 The IS' eventual contribution to the improvement of the quality of services.
- F.63 Other advantages or inconveniences for the health care providers of working with the IS. Problems still to be rectified. Discussions and points of view that vary from that of the IS.
- F.64 Any advice for the IS on how it can improve its operation and impact.

#### **5. The Other Actors' Points of View**

Depending on the situation, other actors, such as local authorities, sanitation authorities, social security institutions of other similar systems, can play a significant role in the IS' operation. Their point of view thus, is important, particularly insofar as the following:

- The IS' contribution the general population's health status and the community's life,
- The efficacy of its operation,
- Its support for improving the health supply,
- Its interest in expanding and duplicating the experience.

The relationship between these actors and the IS must be illustrated.

## **4. Additional Information for the Good Use of the Outline**

### **4.1 Glossary**

#### **Access to health care**

This refers to the possibility of using health services. To ensure that members of the population can have access to health services, it is imperative that financial, organisational (the availability of quality health services) and socio-cultural obstacles be removed.

#### **Council**

Refers here to the decision-making organism responsible for the managing the insurance system, also called insurance committee. Often it is not directly responsible for the execution of activities but has to ensure that the general policies are adhered to. It is termed differently according to the context: Management committee, Executive bureau etc.

#### **Admission Fee**

See membership fee.

#### **Adverse Selection**

There is adverse selection, when the proportion of high-risk category members in an IS is higher than the proportion in the general population. This situation can compromise financial viability, by an expenditure level that is too high per member.

#### **Agreement**

See conventions.

#### **Ambulatory Care**

Care effected in a medical establishment, but without the patient's hospitalisation or confinement. This means that the patient comes there to be rehabilitated and then returns home.

#### **Authorised Providers**

Refers to the providers who have been accepted by the IS to service its members.

#### **Available funds (liquid assets)**

This refers to the range of readily available resources that the IS can use for payment deadlines and other expenses. It usually comprises treasury funds and easily liquidated credit titles.

#### **Balance Sheet**

Periodical balanced inventory of all that a company owns and owes.

### **Basic Healthcare**

Ongoing medical care given to patients in medical facilities. This is the population's first point of contact with the medical system. It comprises preventative and promotional care, simple curative care and nutritional recuperation.

### **Beneficiary**

See member.

### **Benefits/ Contributions Relationship**

As contributions ensure the financing of the benefits, there is a close link between benefits supplied and the contributions requested. Hence, it is common to use the notion of "benefits/ contributions relationship".

### **Benefits Monitor Register**

This is a document that indexes the services granted, by behaviour categories.

### **Budget**

The budget is a management tool, which registers the estimated receipts and expenditure over a given period.

### **Budgeted Contributions**

A term's **commitment contributions** are the contributions which the IS must, in theory, receive from all the current contracts.

**Cash Contributions**, also called received or registered contributions or premiums, refer to all the contributions registered in receipts in the IS' accounts.

The **budgeted contributions** within a given period designate the share of cash contributions, which effectively corresponds to the benefits to be paid during this period. *In the case of an IS, where it is possible to subscribe for the whole year and where the annual term ends on the 31<sup>st</sup> of December, if half of the members contract (for one year) from June 1<sup>st</sup> of that year, the total amount of their contributions will be registered in receipts. However, one cannot assume that these contributions, in their entirety, constitute the term's resources. Half of these contributions have to cover the members' benefits for the next term. It is for this reason that they have to be "reserved" (technical reserves) for the following term.*

The difference between cash and budgeted contributions, is the contributions to be allocated also called technical reserves. These are not considered resources for the current period, and are registered as reserves in the balance sheet.

### **Cash Contributions**

See budgeted contributions.

### **Co-operatives**

This refers to a group of people who have united voluntarily to realise a common goal, by establishing a democratically run company, providing an equitable quota of the necessary capital and accepting a fair share of the risks and the profits of this company. Members also take an active part in its operation.

*(Extracted from Recommendation 127 on co-operatives of The International Labour Organisation.)*

## Co-payment

The co-payment is the share of covered health services, which remains the responsibility of the beneficiaries. The co-payment can take the form of:

- A **ticket moderator** when a percentage of the cost of the covered services is deducted from the amount refunded to the member. The ticket moderator is a percentage of the expenditure. It is called a ticket moderator because it makes it possible to moderate consumption in health expenditure.  
*E.g. The IS is accountable for 80% of the expenditure for hospitalisation. For a US\$100 bill, the IS would reimburse  $100 * 80\% = US\$80$ .*
- A **deductible** when the IS only covers costs higher than a sum fixed in advance. This authorisation is generally fixed in relation to covered services.  
*E.g. The IS has fixed the deductible at US\$30. If the member has a bill of US\$100, s/he will be reimbursed the difference by which the bill exceeds the deductible.  
In this case,  $100 - 30 = US\$70$   
If the bill had been for US\$20, the IS would not be accountable for payment.*
- **Maximum coverage** when the IS does not cover expenditure above an amount stipulated in advance.  
*E.g. If the IS has fixed the maximum coverage at US\$80 for hospitalisations. For a US\$100 bill, the member will be reimbursed US\$80 (if there is no deductible.)*

## Commitment Contributions

See budgeted contributions.

## Compulsory Reference

This refers to the requirement for doctor's referral on a given level before being able to consult any medical practitioner at a higher level. The doctor has to refer the patient to the higher level.

## Context Study

In this case, it indicates all studies designed with an aim to better understand the system's environment, particularly as regards the parameters influencing its functioning.

## Contingency Reserve

This refers to the IS' own capital (as opposed to the social capital which is made up of social capital shares that remain the property of the members). It appears in the passive section of the balance sheet. In insurance systems, the reserve is generally from the term's surplus and is often regulated.

## Contribution (of a member of a mutual)

Also called premium, correspond to an established amount of money, or its equivalent in kind, which is paid, often periodically, to the IS by the member and the other beneficiaries. This entitles them to the guarantees supplied by the insurance. It is sometimes termed differently as premium or quota.

**Contributions Recovery**

This comprises levying the contributions due to the insurance system.

**Contributions Register**

This document allows the registration of contributions made by the members.

**Conventions (between insurance systems and health care providers)**

Concluded agreements between health-care providers and the mutual. This often includes the definition of the services covered, tariffs to be applied and the amount and methods of refunding. Conventions guarantee beneficiaries the possibility of receiving quality care at a reasonable price known beforehand.

**Cost Recovery**

This is the policy or practice in which patients pay for part or all of their care.

**Deductible**

See co-payment.

**Dependants**

Someone who is not a member of the mutual, but benefits from its services, by virtue of familial relationship with a titled member (for example, a spouse, child, or ancestor...)

**Entry Fee**

See membership fee

**Essential Medicines**

Those medicines that are selected by WHO because of their relevance in preventing or treating the most frequent illnesses in a country. The use of this selection allows the improvement of therapy, the guarantee of good medicine usage and contributes to reducing health expenditure.

**Financial Contribution of the State**

This comprises the State's financial contribution to the insurance system. Contributions can be either regular, when payment is repeated and acts as a mechanism of extended State support (either over a given period or not) or exceptional when their payment is concurrent with a particular occasion (opening of activities, acquisition of infrastructure etc.).

**Financial Feasibility Study**

Refers to all studies which, through projections, aim to determine the future financial operation of the insurance system.

The Financial Feasibility Study is one of the common starting points for determining the benefits/contribution relationship.

**Fixed Fee**

Refers to fixed amount paid as benefits to beneficiaries when it is fixed in advance and independent of the real amount of medical costs.

**General Assembly**

The general assembly gathers the range of members. Within organisations that foster a social economy (mutuals, co-operatives and associations) the general assembly is the most important decision-making mechanism and determines general policy and objectives.

### **Generic Medicines**

Medicine designated by the name of its most significant active ingredient, rather than the commercial name. Generally, the International Non-proprietary Name (INN) established by the World Health Organisation (WHO) corresponds to a generic name.

### **Guarantee Funds**

This describes funds, which the insurance system can request in the event of financial difficulties. Once requested they can be provided in the form of a loan. The situations in which guarantee funds can be requested are generally well defined. The IS may be obliged to make certain functional changes as a condition of the loan.

### **Health**

According to the definition of WHO: "health is the complete state of physical, mental and social well being, and does not only include the absence of illness or disability".

### **Health Care Provider**

General term used to describe any person or medical facility, which provides health care to a patient.

### **Health Credit System**

Certain insurance systems allow their members to obtain a health credit. This credit can be granted for 1) the payment of services not covered by the IS and 2) for co-payments on covered services.

### **Health Risks**

In health care, a distinction is made between higher and lower risks. Higher risks are those which imply large expenses, such as hospitalisation, childbirth and surgery. The lower risks are those which imply less expenses. These comprise consultations from general practitioners or the purchase of medicines.

### **Health Savings System**

Some systems offer their members a health savings plan. This savings plan is intended for future health expenses that are not covered by the insurance. Often, the health savings plan is paid by contributing members into individual accounts or through subscription cards valid at selected health care providers. The member buys the card, which contains an allowance of health expenditure. Each time health services are used the cost amount is debited from the card.

### **Health care Supply**

Indicates the range of health services supplied. Also called health care offer or provision of health care.

### **Hospital Care**

Care given in a hospital facility that includes hospitalising the patient. This means a several-day hospital stay.

**Income and Expenditure Statement**

The income and expenditure statement is the summary of the expenditure and income of the IS during a given period, called a term (generally one year.) The result is equal to the difference between the term's expenditure and income. This result is a surplus if the income is more than the expenditure and a loss in the reverse case.

**Insurance**

A system of coverage of risks or uncertain events facilitated by the preliminary distribution of the costs resulting from these risks among several people.

**Insurance Management Units**

Refers to the units that manage the range of contributions and benefits for a given group of beneficiaries. Within small systems, there is usually one unit.

**Insurance Risk-management**

Refers to the range of techniques and procedures designed to reduce adverse selection, moral hazard and cost explosion.

**Internal Regulations**

This document outlines the practical rules and methods of operation, that all members have to respect to allow a good organisation of activities. It supplements the statutes and makes them more explicit.

**Legal/ Juridical Statute**

The legal statute refers to the type of legal character of the system.

**Legal Status**

Legal status could be given to physical and legal persons. The physical person refers the whole human being, while the legal person refers to a group of people to whom the law denotes a legal status separate from that of its members. Like a physical person, the legal person has rights and obligations. The legal status can be obtained through various types of registration: a non profit-making association, co-operatives, mutual companies, limited companies (ltd.), etc.

**Levels of Sanitary Facilities**

This refers to categorising the health infrastructure according to identical functions. Thus the dispensaries and health centres or doctors' offices constitute the first level, district hospitals, the second level and regional or university hospitals, the third level. Sometimes, a reference is needed to proceed from one level to the next (except in emergencies.) This means that to go to hospital one has first, to be referred by the first level.

**Level of Coverage**

Refers to the IS' level of accountability for covering the beneficiaries' medical costs.

**Margin of Error**

Describes the margin introduced to deal with uncertainties relating to certain parameters related to the system's operation. It is generally introduced during the first years of operation.

**Medical or Sanitary Facility**

All structures or institutions concerned with health and which act as health care providers to the population (health centres, dispensaries, doctors' offices, hospitals etc)

### **Member**

This designates the person who subscribes to the insurance system. In the case of mutuals or co-operatives, the member is a constituent of the general assembly and by virtue of this, has management responsibilities. The member in-keeping with the system and the zones, could be designated by other terms, such as: insuree, affiliate, holder, or adherent.

An insurance system may have beneficiaries other than its members. Usually their family members are included as such. However, the rights and obligations of these latter often differ from that of the member. The conditions of coverage also differ largely from one system to another.

### **Members' Register**

See membership register.

### **Membership Fee**

This is a contribution paid by a new member when joining. The membership fee is different from the contribution and is generally paid only once by the member. It often covers administrative costs and is non-refundable when the member terminates his/her membership. The membership fee is also referred to as an *admission fee*, an *entry fee* or a *registration fee*. However, several of these terms can be used within the same insurance system. (For example, membership fee for members and registration fee for beneficiaries.)

### **Membership Register**

This is a registration document that notes members and usually includes the withdrawals (resignations.) The number of members and the beneficiaries are normally included in this register. It is also termed "members' register."

### **Moral Hazard**

This refers to the phenomenon in which insurance beneficiaries use the services provided either abusively, or more than ordinarily, in order to take full advantage of the contributions that they have paid.

### **Mutual Health Insurance**

These are democratic organisations founded on mutual aid and solidarity. They are created and managed by the members for the members. Mutuals often manage health insurance among other things.

### **Precaution**

This describes an attitude that involves taking a certain number of disaster-preparedness measures. For example, storing foodstuffs in case of a drought or shortage, saving for marriage, etc.

### **Preliminary Funds**

This refers to a fund created during the IS' launch to guarantee the financing of the first benefits although reserve funds are not yet existent. The preliminary funds are brought by operators other than the members.

**Preventative and Promotional Care**

This comprises pre and post-natal consultations, follow-up of healthy babies, vaccinations, family planning, health education, cleansing.

**Primary Healthcare**

Strategy of sanitary development based on improving the quality of health services at the first level, based on the curative aspect of preventative and promotional interventions, and by encouraging the active participation of the population.

**Premium**

See contribution.

**Reference System**

See compulsory reference.

**Registration Fee**

See membership fee.

**Received Income on Invested Funds**

This indicates the interests received by the IS on funds, which it invested.

**Reinsurance**

The reinsurance is a mechanism according to which, the insurance system itself is insured by another insurance. It refers then, to the insurance of the insurer. It is a second-level insurance, which directly links the insurer to a re-insurer. This mechanism allows a diversification of the risk and creates a larger risk-pooling base.

**Risk**

The probability that a situation (good or bad) will arise. By extension, it refers to insurance from an undesirable event. The principle social risks are: illness, disability, old age, unemployment and death (see social security.) Positive social risks include marriage and birth.

**Risks of cost explosion**

Health care providers can trigger off a rise in services by prescribing worthless care. The patient complies since s/he knows that s/he is insured.

**Sanitation Authorities**

This refers to the public health systems (or people) responsible for the zones covered by the system. Sanitation authorities differ from health care providers by their mandate, which is not to offer health services but generally to promote health care and to regulate the sector.

**Social Capital Share**

In some organisations, particularly in co-operatives, the member has to participate in creating social capital. This participation is realised through the acquisition of social capital shares. The methods of applying social capital shares differ greatly according to the situation. The social capital share is generally refundable to the member when membership is terminated.

**Social Control**

Represents the internal control resulting from the existence of social relations between the members (they know each other, they are from the same ethnic group, etc.) It does not constitute a formal mechanism of control.

**Social Protection**

General term covering all guarantees against reduction or loss of income in cases of illness, old age, unemployment or other hardship, and including family and ethnic solidarity, collective or individual savings, private insurance, social insurance, mutual benefit societies, social security, etc.

*(According to the thesaurus of the International Labour Office, Geneva, 1991)*

**Social Security**

Compulsory national schemes founded generally on principles of universality (e.g. protection of the total population) and on a unified general coverage against economic and social destitution. This could be caused by the disappearance of or a significant reduction in their income, illness, maternity, work accidents and professional illnesses, unemployment, disability, old age or death. This loss could also include, the provision of medical care and social services for families with children (according to Convention 102 of the International Labour Organisation concerning social security [minimum norm.])

**Specialised Medicine**

Medicine practised by specialist doctors, such as dermatologists, cancerologists and gynaecologists etc.

**Specialised Care**

Consultations with specialised doctors (gynaecologists, paediatricians, surgeons etc) as well as technical medical examinations (radiology, clinical biology etc.)

**Statutes**

This refers to the range of conventions and rules adopted to define objectives, the way of functioning, the rights and obligations of the members, the agents, their responsibilities and their relationships, etc. The broad outline of the statutes is generally fixed by legislation.

**Surplus**

This refers to the difference between the income and the expenditure for the term, when income is higher than expenditure. Depending on legislation and the legal statute of the IS, different terms, such as revenue and profits can be used.

**Target Group**

Refers, not only, to current beneficiaries of the insurance system, but also potential ones. The target group can comprise several sub-groups of people with similar characteristics (income level, economic sector, etc.)

**Technical assistance**

Indicates the unremunerated support the system receives. In this regard, technical assistance differs from service provision. Technical assistance is most often provided by

projects, NGOs or government services. However, the efforts made by these services insofar as control and regulation are not regarded as technical assistance.

**Term (Fiscal)**

The period in which the IS balances its financial statements. The choice of term is often regulated.

**Term Expenditure**

These expenses constitute what was consumed during the (fiscal) term (benefits, personnel costs, depreciated equipment etc.) They are the opposite of (fiscal) term income, but not necessarily equivalent to costs.

**Third Party-Payment**

Describes a payment system for health expenses in which the member only pays the care provider the part of the cost for which s/he is responsible (ticket moderator.) The IS pays the supplementary costs directly to the care provider.

**Ticket Moderator**

See co-payment.

**Transfer Assets**

Sale or gifts of assets (the assets appear in the balance sheet. They include fixed assets, stock, investments, etc.)

**Treasury Plan**

This involves prediction of the treasury needs and the means of financing selected to respond to them. It makes it possible to envisage, on a monthly basis or over shorter periods, the funds that the IS will need to conduct its short-term engagements.

**Unprogrammed medical hospitalisation**

Unforeseen hospitalisation resulting from infections or acute complications, accidents, etc. These are the opposite of programmed hospitalisation.

**Waiting Period**

This refers to the time during which, a new member has no right to the services provided by the insurance, although contributions are already being paid. This period is necessary to deter people from registering only at the moment when care is needed and then terminating membership after the service has been provided. (For example, joining in anticipation of childbirth.) In principle, the waiting period, which is also termed the probationary period or the observation period, is not applied to all services covered.

## 4.2 Explanations of points raised in the outline

### I. Part A

- A.2: The IS could be linked to an organization with other activities. For example, to a producer's organisation, which sells coffee, or a mutual providing savings/ credit services. Here, you are required to provide the name of the organisation to which the IS is attached.
- A.4: This refers to the date (approximate) of the IS' conception?
- A.6: See A.2
- A.8: The answer to this question must be affirmative if the IS has been registered and is recognised by the competent authorities.
- A.10: The IS can allow the simultaneous membership of unaccompanied individuals, families or groups. Family membership refers to the membership of a family as a group, and not protection of a member's family
- A.11: Certain systems allow the coverage of a members' dependants, outside his/ her family. Certain IS offer benefits to the poorest who are not members (there is no payment of service charges and/ or contributions).
- A.12: Voluntary membership refers to the fact that the member is free to choose whether to join the system. Automatic membership occurs when an individual's membership to another group (co-operative, village, trade union, etc.) systematically makes him /her a member of the insurance system and this systematic membership results from a group decision and not from external imposition. Compulsory membership refers to those systems in which individuals or groups are not free to decide their membership.
- A.15: The number of IS members is not necessarily the same as the number of members of its parent company.
- A.18: It will be difficult to find the exact figures here. Estimates will be given. In the report, it is necessary to explain the basis on which these were formulated.
- A.20: This refers to the zone(s) where the IS has members, and not the zone where the target group is located.
- A.23: "Other contributions" refers to those contributions paid by persons (legal or physical) other than the member. It could mean, for example, contributions paid by an employer or by another organisation to which the member belongs. "Other contributions" is different from " contributions and subsidies from other sources" because in this case, contributions are paid on behalf of the designated member and not given as aid to the IS.
- A.27: The situation described by the second item is that encountered in most insurance systems created by health care providers.

- A.28: "Management entrusted to a public or private operator" refers to the cases where the IS is not insured by its parent company or by its own agents, but by an external organisation commissioned specifically for this reason.
- A.29: "Regular technical assistance" refers to the technical assistance where support is provided to the IS continuously in the framework of a medium term relationship between the IS and the organisation providing the technical assistance. "specific technical assistance" refers to other forms of technical assistance.

## **II. Part B**

- B.8: When writing in the salary, do not forget to indicate the corresponding period: day, week, month, etc.
- B.11: The definition of the informal sector used for the development of the data should be specified.
- B.14: " Access to social services" refers to access to education, housing, nurseries, civic information, etc. Access to health care is dealt with elsewhere.
- B.18: It may be interesting here, depending on the situation to classify the frequency rates according to the levels of sanitary infrastructure.
- B.19: You must indicate clearly to what extent the health policy projects the contributions of the users to health care financing (partial or total payment for care). In terms of the "population's role", it is equally important to indicate if the latter's participation in managing the health benefits package (for example, co-management of health centres by committees elected by the communities) is projected and is effective in practice.
- B.26: "Traditional forms of solidarity", refers to the usual practises. They are often linked to the customs, communities (or sub-groups) and are destined to help those who cannot rehabilitate themselves (or their families) because of financial difficulties.

## **III. Part C**

- C.3: It is possible that the target group was not defined from the beginning. If this was the case, indicate it.
- C.4: The target group can be representative of the range of the population of the IS' zone or, on the contrary, it could comprise a sub-group with specific characteristics (for example, income level, economic sector, etc.)
- C.5: Here, the different types of difficulties that the target group may encounter must be considered: distance or unavailability of services, mediocre quality, price, etc. These difficulties, if they exist, must be differentiated according to the type of services (primary health care, hospitalisation, etc.).

- C.9: This could refer to a person, an organisation, or a group of persons.
- C.10: This concerns identifying the needs (of the target group) to which the IS' creation may respond.
- C.16: "Context study" refers to all studies aimed at analysing the operation parameters of the prospective IS and which are determined by the IS' context: availability and quality of the health care offer, health policy, legislative framework, demography, etc.
- C.20: The first question refers to any type of insurance (goods, death, health, etc.).
- C.22: It is interesting to obtain, if they exist, the minutes from meetings or assembly generals to better determine the attitude of members to the IS' creation.
- C.27: This could refer to an organisation or a person other than those who introduced the idea of creating the IS or conduct the various preparatory activities (identifying needs, studies, etc.).
- C.30: The IS can allow simultaneously the membership of unaccompanied individuals, families, or groups. Family membership refers to membership of a family as a group and not to the protection of members' families.
- C.31: Voluntary membership refers to the fact that the member is free to choose whether to join the system. Automatic membership occurs when an individual's membership to another group (co-operative, village, trade union, etc.) systematically makes him/ her a member of the insurance system and this systematic membership results from a group decision and not from external imposition. Compulsory membership refers to those systems in which individuals or groups are not free to decide their membership.
- C.34: Certain systems allow the coverage of dependants, other than members' families. Certain IS offer benefits to the poorest who are not members (there is no payment of membership fee and/ or contributions).
- C.46: Whenever different billing systems are used, it has to be specified whether they correspond to different categories of health care providers, such as those defined in C.42.
- C.47: "Conventions" refers to the formal agreements (at least those written). If only verbal agreements have been established, indicate what they are.
- C.50: The IS' management can involve several organisations, each having their own mandate. For example, organisation A may be the IS' proprietor, and consequently have decision-making power in organising management responsibilities. Organisation B may be authorised to manage the insurance, organisation C to implement management control.
- C.55: Here, documents which are named differently from those given in C.55, but which fulfil the same purposes, must be considered.

#### **IV. Part D**

- D.2: It is sufficient here, to indicate the main categories of persons excluded from the target group.
- D.7: There may be several types of restrictions to subscription periods. For example, an IS may limit the subscription period to a certain number of months or years after its creation date, or until a potential member fulfils certain criteria (age, membership to an organisation, etc.) The possibility of membership could be offered only at a certain time of the year, for example, from this month to that month.
- D.13: For this point, as with the range of those points related to the evolution of the IS' characteristics, it is included in the situation described at the end of the first year. (Part C).
- D.17: Exclusion, comprises loss of membership status due to non-observance of statutes and regulations (fraud, non payment of contributions, etc.)
- D.18: See section 4.3 for a definition of the penetration rate. It would be beneficial to indicate all changes to the target group, which would modify the penetration rate.
- D.25: This does not refer to differences due to subscription to different benefits categories, but to differences due to members "characteristics". For example, certain benefits may not accessible to members over a certain age or to those who live too far from corresponding health services.
- D.53: The IS may organise prevention or health education programmes itself or, may favour programmes of this kind, managed by other organisations, which influence its beneficiaries. Also indicate the cases where the IS favours the creation of health education/promotion programmes which are not intended exclusively for its members.
- D.58: The officials' points of view must be indicated (and present it as such in the report).
- D.60: This point is particularly important when members are unsalaried.
- D.61: "Groups of people" indicates the cases where groups and not their members, must pay contributions, as for example with a co-operative or trade union.
- D.63: This does not refer to automatic coverage of certain individuals, related to the member, as for example is the case in certain systems where the spouse of the member is automatically protected without additional contribution payments. "Exemption" refers to the cases where, for specific reasons, someone, receives benefits without having to pay the normal contributions required.
- D.64: This could refer, for example, to contributions paid by employers.

- D.67: The IS is not necessarily the organisation that receives contributions payments. The latter could be for example an organisation authorised to manage the insurance.
- D.81: This refers to contributions that could have been made before the last three terms and after the end of the first year of operation (Part C deals with those made before this date).
- D.82: As indicated in the sub-title, this does not refer to donations and subsidies given by the State. The preceding sub-title **c)**, deals with that aspect.
- D.85: Indicate clearly the concrete elements (separation of accounts, accountabilities, responsibilities for management, etc.) which show this separation or on the contrary, the fusion of the IS' financing and that of its parent company's other activities. IS' officials often affirm separation, without it being actually practised.
- D.88: For this point, and for others about cost, you must indicate the data's source. It is also important to specify the constituent cost headings (the same term can describe very different realities depending on the IS).
- D.90: "Other operation costs" refers to the range of costs excluding management costs and the cost of benefits.
- D.91: To determine the profit-making status of the IS, you must consider the designation by national legislation and not that stated by its officials. For example, some co-operatives that operate in different countries, although they have the same activities are, considered profit or non profit-making depending on legislation.
- D.93: Remarks are the same as for D.88.
- D.98: "Type" (column 3) here you are required to specify whether it is a public, private, profit-making, or non profit-making health care provider.
- D.101: It is important to indicate whether the health care provider is free to establish agreements or contracts with third parties. Indicate whether there are gaps between "policy" and what is actually practised.
- D.103: "Problems with availability" also includes disruption in the delivery of a service (for example, linked to problems in medical supplies, insufficient infrastructure for the sick, personnel rotation) as well as an abnormally long delays.
- D.107: In third-party systems, health care providers normally carry out control of the right to benefits.
- D.110: The term "participate" is used in the broad sense. Health care providers' simple consultation with the beneficiaries, or IS officials about managing their activities should be mentioned.
- D.114: It is important to mention the eventual differences in the opinions of health care providers and the IS on billing methods.

- D.122: The IS' management can involve several organisations, each having their own mandate. For example, organisation A may be the IS' proprietor, and consequently have decision-making power in organising management responsibilities. Organisation B may be authorised to manage the insurance, organisation C to implement management control.
- D.124: The IS can include various units. It could mean decentralisation of functions, for example: contributions collection by village units, managing the insurance by a group of villages. It could mean decentralisation of location, for example: unit A manages the insurance in zone A, unit B in zone B, etc. There are many possible formulas.
- D.132: This refers to information given to members after membership. The preceding point deals with information provided at the time of subscription.
- D.152: External control refers to control enforced by organisation or persons who are not members of the IS and whom, apart from this, have no responsibilities in its management.

#### **V. Part E**

For this part, refer to the section "Definition of Indicators".

#### **VI. Part F**

- F.2: "Internal evaluation" refers to evaluations carried out by people or organisations who belong to the IS or its parent company.
- F.5: "External evaluation" refers to evaluations other than those mentioned in F2.

### **4.3 Definition of Indicators**

As indicated in the introduction, the analytical importance of the case studies, which are the object of the guide, remains limited. In particular, these case studies do not aim to analyse the efficiency or viability of the systems. Nevertheless, it is interesting to show the operation indicators established by the IS, when they exist. You are not however required to produce these indicators.

The formulas used to calculate the different indicators presented in part E of the outline are shown below. These formulas are not given to calculate the indicators during the development of the study, but to specify their content. A brief description of the functioning of each indicator is also given.

One will note that several indicators can be calculated for members only or for the range of beneficiaries. They are presented here, according to their most frequent usage.

Other indicators can be used, following the particularities of the systems, the accounting plans, and legislation. These indicators must be presented in chapter VI of the report. Indicate clearly how they were calculated and what are their functions.

For each indicator, it is very important to specify the calculation formulas used by the IS to calculate it, as well as their corresponding periods. If it is possible, provide the value of the indicators for the last three terms.

## **(a) The membership dynamic**

### **\* Target group's penetration rate (E.1)**

*It is equal to  $Y*100/X$  where:*

- *Y is the total number of beneficiaries;*
- *X is the total number of members of the target group.*

The penetration rate shows the target group's interest in the system, the latter's growth potential, how representative the beneficiaries are, etc. This indicator could be broken down into penetration rate among women, men, or age groups.

### **\* Proportion of members who do not belong to the target group (E.2)**

*It is equal to  $X*100/Y$  where:*

- *X is the number of beneficiaries who do not belong to the target group;*
- *Y is the total number of beneficiaries.*

This proportion indicates how much the IS focuses on other groups in the population, apart from the target group. A high proportion could mean a difficulty for the IS to reach the target group and consequently to fulfil its fixed objectives.

### **4.3.1.1.1 \* Number of members growth rate (E.3)**

*It is equal to  $(Y-X)*100/X$  where:*

- *X is the total number of members in year N-1;*
- *Y is the total number of members in year N.*

The growth rate allows one to follow the relative growth of the IS' size during a given period. This growth constitutes a significant parameter to consider for good management of the IS.

### **\* Re-contribution rate (E.4)**

*It is equal to  $Y*100/X$  where:*

- *X is the number of members in year N-1;*
- *Y is the number of members in year N-1 who contributed again in year N.*

The rate of re-contribution shows how interested members are in the system. A weak rate shows members disinterest, or is symptomatic of problems in the IS' operation.

### \* **Growth rate unrelated to geographic extension (E.5)**

*It is equal to  $(Y-X)*100/X$  where:*

- *X is the number of members in year N-1;*
- *Y is the number of members in year N in areas where the IS already operated in year N-1.*

This rate shows the evolution of the number of members in the IS' old zones. It allows better placement of the membership dynamic when the system developed its activities in new zones. The general evolution of membership could mask opposing dynamics in new and old zones.

### \* **Growth rate linked to geographic extension (E.6)**

*It is equal to  $Z*100/X$  where:*

- *X is the number of members in year N-1;*
- *Z is the number of members in the IS' new zones of implantation (less than 12 months).*

This rate provides a measurement of the dynamic of geographic extension and the development of the IS.

### \* **Average number of beneficiaries per member (E.7)**

*It is equal to  $Y/X$  where:*

- *X is the total number of members;*
- *Y is the total number of beneficiaries.*

This number is a significant indicator to observe in insurance companies where contributions paid by the member are independent of the number of dependants and in those where only a complementary contribution per dependant is requested. In these two types of systems, it is a determining factor of financial viability.

## **(b) Service Use**

### \* **Consumption rate of covered health services (E.8)**

*For a type of service W, it is equal to  $X*100/Y$  where:*

- *X is the number of times the beneficiaries used services W during year N;*
- *Y is the total number of beneficiaries in year N.*

See below for meaning

### \* **Health services consumption rate of beneficiaries to non-beneficiaries (E.9)**

*For a type of service W, it is equal to  $X*100/Y$  where:*

- *X is the consumption rate by beneficiaries of type W services covered;*
- *Y is the consumption rate of the same services by non-beneficiaries.*

The evolution of health service use by beneficiaries compared to that of other users is an interesting indicator of the IS' performance. Nevertheless, if an increasing rate can mean better access to health care, it can also result in over-consumption or degradation in the quality of care.

**\* Exclusion rate from covered health services (E.10)**

*It is determined by survey. It is equal to  $X*100/Y$  where:*

- *X is the number of beneficiaries in the sample who cannot rehabilitate themselves using the services covered;*
- *Y is the total number of beneficiaries in the sample.*

The exclusion rate from covered health services indicates the persistence of problems related to accessibility of services covered. These problems could have multiple causes (level of co-payments, availability or quality of services, etc.) which the survey has to identify.

**\* Evolution of the average amount of benefits per beneficiary (E.11)**

*It is equal to  $(X-Y)*100/ Y$  where:*

- *X is the amount of benefits per beneficiary in year N;*
- *Y is the amount of benefits per beneficiary in year N-1.*

From the evolution of the amount of benefits per beneficiary, health care consumption can be monitored. If benefits are defined according to categories, it will be easier to identify the causes in rate fluctuations and, if necessary to take corrective measures (for example, to limit over-consumption or improve access to health care).

**\* Average cost of services for the beneficiaries and non-beneficiaries (E.12)**

*For a category of health care W, it is equal to  $(X+Z)/Y$  where:*

- *X is the average cost of benefits supplied by the IS for health care W;*
- *Z is the amount of the co-payment for health care W;*
- *Y is the average cost of health care W for non-beneficiaries.*

The average cost is important insofar as establishing the IS' financial equilibrium. The relationship between average cost of services for beneficiaries and non-beneficiaries allow one to identify eventual over prescriptions.

## **(c) Financing and the Financial Situation**

### **\* Surplus (deficits) (E.13)**

*It is equal to  $X-Y$  where:*

- X is the term's total income;*
- Y is the terms' total expenditure.*

The term's balance (surplus or deficit) is a fundamental indicator of the IS' operation. Deficits presuppose the introduction of corrective measures lest the IS disappear.

### **\* Total amount of benefits (E.14)**

This refers to the total amount of benefits provided (paid and about to be paid) by the IS to its beneficiaries during a term.

The total amount of benefits shows the volume of the IS' activities.

### **\* Contributions recovery rate (E.15)**

*It is equal to  $X*100/Y$  where:*

- X is the amount of contributions paid for a given period;*
- Y is the total amount of contributions that the IS should theoretically receive for that same period.*

A rate close to 100% demonstrates active participation and prefigures good benefits coverage by the IS. Inversely, a weak rate indicates difficulties (high level of contributions, bad synchronisation between contributions payment periods and income periods, members' dissatisfaction, etc.) and can compromise the IS' financial equilibrium.

### **\* Percentage of members whose contributions are current (E.16)**

*It is equal to  $X*100/Y$  where:*

- X is the number of members whose contributions up-to-date;*
- Y is the total number of members.*

This indicator enhances the information given by the preceding indicator.

### **\* Immediate liquidation ratio (E.17)**

*It is equal to  $(X+Y)/ Z$  where:*

- X is the amount of credits in the petty cash;*
- Y is the amount of immediately available funds in the bank;*

- Z is the amount of short-term debts.

This ratio measures the IS' short-term solvency. That is its capacity to handle debts due in the short-term.

**\* Solvency ratio (E.18)**

It is equal to  $X/Y$  where:

- X is the amount of resources available to the IS, without taking out a loan;
- Y is the total amount of its debts.

The solvency ratio indicates the IS' ability to pay its debts in the short and medium term without taking out a loan.

**\* Budgeted contributions/ term expenditure ratio (E.19)**

It is equal to  $X/Y$  where:

- X is the amount of budgeted contributions for the term;
- Y is the amount of the term's expenditure.

This ratio allows one to appreciate the extent to which contributions adequately cover expenditure.

**\* [Budgeted contributions + regular contributions]/ term expenditure ratio (E.20)**

It is equal to  $(X+Z)/Y$  where:

- X is the amount of budgeted contributions for the term;
- Z is the amount of regular contributions paid (for example, by the State or local collectives) during the term;
- Y is the amount of the term's liabilities.

This ratio is a variation of the preceding one. It is applied in systems that benefit from regular financial contributions from third-parties.

**\* Management costs / [Budgeted contributions + regular contributions] ratio (E.21)**

It is equal to  $Y/(X+Z)$  where:

- X is the amount of budgeted contributions for the term;
- Z is the amount of regular contributions paid (for example, by the State or local collectives) during the term;
- Y is the management costs. That is the range of liabilities aimed at the administration and management of current operations, such as salaries and indemnities, premises, furniture, endowment liquidation, etc.

This ratio and its evolution are important indicators of the IS' efficacy in administration and management of its current operations.

**\* Ratio of benefits coverage by reserves (E.22)**

*It is equal to X/ Y where:*

- *X is the value of reserves at the end of the term (after surplus allocation);*
- *Y is the amount of benefits paid during the term divided by 12.*

This ratio indicates the IS' financial strength. A minimum value of this ratio is sometimes fixed by law.

**\* Benefits/ budgeted contributions ratio (E.23)**

*It is equal to X/ Y where:*

- *X is the total amount of benefits for the term;*
- *Y is the total amount of budgeted contributions for the term.*

This ratio indicates to what extent the contributions are used to pay benefits. If this ratio is weak, there is an inefficacy problem (for example, management costs may be too high) or an over-estimation of contributions.

**\* Rate of internal financing (E.24)**

*It is equal to X/ Y where:*

- *X is the total amount of IS' own resources. That is, the range of resources generated by its activities and contributions without including that given by the State or external parties;*
- *Y is the IS' total amount of operation costs including costs assumed by external operators and which are not included in the IS' accounts. For example, costs for personnel provided to the IS certain training or promotional activities.*

This rate indicates the extent to which the IS is able to tackle the range of costs using its own resources.

**\* Payment period of health care providers (E.25)**

*This refers to the average period between the date that the IS receives the invoices from the health care providers and the date when they are paid.*

Payment periods that are too long indicate treasury difficulties or administrative problems. This could compromise the relationship between the IS and health care providers.

**\* Beneficiaries' reimbursement period (E.26)**

This refers to the average duration between the date that a reimbursement claim is made to the IS and the date which it is paid.

**(d) Members' Participation**

**\* Frequency of general assemblies/ reunions (E.27)**

This is the number of general assemblies or meetings for members per year.

This is the first indicator of members' participation in the IS' operation.

**\* Frequency of members' opinion polls (E.28)**

The number of opinion polls aimed at members or beneficiaries during the last three years.

It indicates the importance given to members' (or beneficiaries') needs and opinions in the IS' operation.

**\* Participation rate at general assemblies or meetings (E.29)**

This is the relationship between the number of participants and the total number of people invited to these general assemblies or meetings. This can be calculated in the same way for insurance councils or committees.

A rate close to 100% indicates that members participate and are highly motivated.

**\* Participation rate in elections (E.30)**

This is the relationship between the number of voters and the total number of persons with the right to vote.

This rate indicates the extent to which the mutual's operation is democratic and allows member participation. This illustrates members' involvement in its functioning.

## **Appendix No. 1: Standard Plan of the Report**

- I. Introduction**
- II. Synthetic Description of the Health Insurance System**
- III. The Context in which the Insurance System Operates**
  1. Demographic Aspects of the IS' Zone of Operation
  2. Economic Aspects
  3. Social Aspects
  4. Sanitation Indicators
  5. National Health Policy
  6. Supply of Health Care
  7. Social Protection in Health
- IV. The Implementation of the Health Insurance System**
  1. The IS' Launch
  2. The Phases of the IS' Implementation
    - 2.1 Identifying Needs and Defining Objectives
    - 2.2 Context and Financial Feasibility Studies
    - 2.3 Information on the Target Group
    - 2.4 The Launch of Activities
    - 2.5 Leadership and Decision-making
  3. Operation during the First Term
    - 3.1 Members and Other Beneficiaries
    - 3.2 Benefits
    - 3.3 Financing
    - 3.4 Health Care Providers
    - 3.5 Administration and Management
  4. Technical Assistance and Training

## **V. The Insurance System's Characteristics**

1. The target group and the beneficiaries
  - 1.1 The Target Group
  - 1.2 Various Categories of Beneficiaries
  - 1.3 The Number of Beneficiaries and its Evolution
  - 1.4 Reasons for Losing Membership Status
  - 1.5 Target Group's Penetration
2. Benefits and Other Services Offered by the Insurance System
  - 2.1 Health Services Covered by the Insurance System
  - 2.2 Benefits Payments
  - 2.3 Other services provided for members
3. Financial Aspects of the Insurance System's Operation
  - 3.1 IS' Finance Sources
  - 3.2 Costs
  - 3.3 Surplus Allocation
  - 3.4 Reserve Funds
4. Health Care Providers
  - 4.1 Health Care Providers Linked to the Insurance System
  - 4.2 The Relationship between the Health Care Providers and the IS
  - 4.3 Payment of health care providers
5. The Insurance System's Administration and Management
  - 5.1 Statutes and Regulations
  - 5.2 The IS' Management Organisation
  - 5.3 The Democratic and Co-operative Character of Management
  - 5.4 Financial Management
  - 5.5 Information System and Management Tools
  - 5.6 The Function of Control
  - 5.7 Role Distribution

- 5.8 Equipment and Infrastructure
- 6. Actors in Relation to the Insurance System
  - 6.1 Reinsurance and Guarantee Fund Systems
  - 6.2 Technical Assistance
  - 6.3 Social Movements and Social Economy Organisations
  - 6.4 Other Actors

## **VI. The Indicators of the Insurance System's operation**

- 1. The Membership Dynamic
- 2. Service Use
- 3. Financing and the Financial Situation
- 4. Members' Participation

## **VII. The Actors' Point of View vis-à-vis the Insurance System**

- 1. Evaluation Processes
- 2. The Officials' Points of View
  - 2.1 The IS' Implementation
  - 2.2 The Membership Dynamic
  - 2.3 Access to Health Services and the Relationship with the Health Care Providers
  - 2.4 Contributions Payment
  - 2.5 Determining the Contributions/Benefits Relationship
  - 2.6 Insurance Risk-Management
  - 2.7 Fraud
  - 2.8 Administration and Management
  - 2.9 Relationship with the State (federal, national, provincial) and Local Communities
  - 2.10 General Operation
- 3. The Beneficiaries' Points of View
- 4. The Health Care Providers' Points of View

6. The other actors' points of view

## **VIII. Conclusions**

### **Appendix**

#### **Remarks:**

1. The study's report should also include the following elements:
  - a table of contents;
  - a list of tables and graphics;
  - a foreword;
  - a list of abbreviations;
  - and, eventually a geographical map, illustrating the IS' location.
  
2. Additional indications for the development of the report
  - 2.1 Introduction

The introduction should give the reader a quick overview of the IS' context, its location, the reasons for its creation and its beneficiaries.
  
  - 2.2 Conclusion

The conclusion should:

    - comprise a brief summary (descriptive) of the elements dealt with in sections III, IV, V, VI of the report.
    - highlight the IS' interesting and particular characteristics
    - present the point of view of the person conducting the study: the IS' weak and strong points and its viability.

## Appendix No. 2 : Control List

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### **Appendix No. 3 : Availability and quality of information**

Answer the following questions and add any significant data linked to the availability and quality of information.

1. What sources of information were used to conduct the study? Who were the people consulted?
2. For what aspects of the IS' operation was it difficult to find the information requested? What kinds of difficulties were encountered?
3. Generally, how viable, do you think, is the information that you were able to obtain? For what aspects of the IS' operation do you think the information is the most doubtful?
4. In the case where the parent company has different activities, do you think the method of accounting allowed a clear separation between data regarding the IS and the others?
5. In the case where the indicators included in Part E of the outline, were not available, does it seem difficult to develop them? For what reasons?

## Appendix No. 4 : Guide Appreciation Record

1. What pleased you in this guide?
2. What did not please you or worried you about the guide?
3. Do you think the orientation of the outline should be changed? If so, in what way?
4. Apart from the specific situation of the IS that you have studied, what points, in your opinion, should be incorporated or deleted from the outline?
5. What constraints have you found in moving from the outline to the report? What changes to the procedure given, do you suggest?