



Micro Health Insurance Community-Based Model

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Structure

1. What is a community-based model ?
2. Why was/is this approach implemented in West Africa?
3. Do the mutual health organisations function (well) and are they effective ?
4. What are the specific origins of the problems ?
5. What is the added-value of this model ?

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1. What is a community-based model ?

- Definition Problem :
Literature review: as many definitions of « community-based model » as the number of community-based approaches/organizations/specialists
- In this presentation:
 - Ideal-Type : Mutual Health Organisations (*Mutuelles de santé*)
 - Main geographical reference : West-Africa

1. What is a community-based model ?

Essential features:

- Improve access to health care through risk-sharing/resources-pooling
- Non-For-Profit
- Mutual interest organizations (*owners/ deciders/policyholders = members*). Which implies:
 - *Participation mechanisms (design of the insurance product, and organisational options)*
 - *Control mechanisms (organisational and financial)*
- No (medical-based) selection of the members



1. What is a community-based model ?

Essential features:

- Voluntary membership
- Based on groups sharing common characteristics (members of a same organisation, villagers, etc.)
- Promotion of solidarity, democracy, social cohesion, etc.
- Potential functions beyond the insurance function
 - Representation of interests (health care demand side)
 - Regulatory function
 - Opposing power



1. What is a community-based model ?

Consequential features:

- Institutionalisation process: set-up often implies the creation of a new organisation autonomous from the initiating organisations (CBOs, NGOs, professional organizations, etc.)
- Self-Management and voluntary work (as a way to avoid a breakage between management and beneficiaries + cost reduction)
- Trust and Social Cohesion Factors ⇔ Homogeneity of the membership



2. Why was/is this model implemented in West-Africa?

- Few relevant alternatives regarding the context
- Context of a nascent civil society in the early 90's
- Influence of European history
 - Social protection models
 - Relation State-Civil Society
- Profile and background of the external support organisations
 - Western NGO/Mutual Health Organisations
 - International Organisations(ILO)
 - Bilateral Development Co-operation Agencies (French/Belgian/German)

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3. Do the MHOs function and are they effective ?

How to answer these questions ?

Are the MHOs effective ?

We know very few about the effectivity of the community-based insurance systems (lack of monitoring systems/availability of comparable data/lack of research).

Do they function (well) ?

We know quite well the organisational related issues

Reference : objectives and rationale of the organisations

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3. Do the MHOs function ?

- Management : discontinuity due to voluntary work, lack of motivation and management skills.
- Participation and decision-making: various levels of participation (*learning phase ? power concentration?*)
- Control mechanisms are barely effective
- Positive Trends of Institutional Viability: continuous changes and arrangements towards more efficiency.
- Low membership (< 1000 beneficiaries ; with several particular exceptions in Senegal, Benin*, Guinea Conakry*)
- Slow membership growth (*intern/extern growth ?*)



3. Do the MHOs function?

- Premiums:
 - Low Premium levels
 - Low premium recovery rates / high drop-out rates (*satisfaction of the members ?*)
- Benefits:
 - Primary/Secondary Health Care
 - Public Sector



3. Do the MHOs function ?

- Discontinuous social marketing (*communication methods ? costs ?*)
- No rigorous application of rules/ sanctions (*hindered by social cohesion and proximity?*)
- Unequal power balance between MHO's and health providers



3. Do the MHOs function and are they effective ?

Unsolved priority questions especially at the micro-level :

- Appropriate design methodology of insurance product ?
- Membership profile ?
- Determinants of affiliation and participation ?
- Why do so many members not pay their premium ?
- Effects/Impact of the membership
 - impact of being insured (more visits when ill, smaller out-of-pocket expenditure when visiting, etc.) ?
 - social effects of being member (better representation, improvement of quality of health care) ?

4. Specific origin of the problems

Context-related problems

- Limited knowledge of complex health seeking behaviour
- Insurance systems initiated and run by young, multipurpose and often inexperienced civil society organisations
- Limited health care supply and weak/bad quality of health care
- Closed health systems where the new actors are not always welcome (lack of incentives)
- Slow effective translation of the official political will (lack of effective policy)

4. Specific origin of the problems

Model-related problems/limits:

- Limits of self-management and voluntary work
- Social participation-based Process = slow process
- Social factors play a role in several areas: membership and determinants of adhesion; leadership profile ; strict management, etc.
- Stress on financial accessibility: low premiums
- Limited scaling-up potential
- Complex setting due to the diversity of involved actors
 - Initiating Organisation (social mobilisation and technical support)
 - Technical Support Organization (distant and sporadic intervention)
 - Union/Federation (when existing)

4. Specific origin of the problems

External support-related problems/limits :

- Experimentation phase (new social engineering)
- Taking into account the timeframe needed by social participation process (>< project timeframe)
- Emphasis on social aspects ; inadequate attention on technical aspects (insurance product design)
- Lack of training offers, human resources, etc.

4. Specific origin of the problems

External support related problems/limits :

- Rationale choices (motivated by institutional sustainability preoccupation and/or cost reduction constraints) :
 - Intensive and financial support often limited to the start-up phases
 - Promotion of self-management and voluntary work
 - Participative approach : active involvement of the target group/membership during the set-up (including feasibility study)

Inadequacy between the nature of community-based organisations and the design of the support intervention (?)

5. What is the added-value of a community-based model ?

Two sets of observation ?

- Access to Health Care issues are not only a matter of insurance
- Participation and control are not only a matter of « client's satisfaction » or « client education »
- Effective social protection reform process needs discussion with and representation of the health care demand-side

- MHOs are more than institutions selling insurance products to clients
- MHOs have to be assessed on their insurance function effectiveness
- ...but not regardless of the social participation process MHO's also represent

5. What is the added-value of a community-based model ?

Added-Value ?

- Emphasis on accessibility
- Embedded Control & Participation Mechanisms
- Functions beyond insurance : representation & opposing power

Questions ?

- How can MHOs be better supported in order to fulfil their multipurpose functions, taking into account their rationale ?
- Is this model relevant without broader redistributive social protection mechanisms/policy ?