AssEF's Experience with Health Micro Insurance

Making insurance work for the poor – Munich, 18-20 October 2005

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The Women's Self – Help Association

- ✓ MFI set up in 1999 in Cotonou, Bénin
- ✓ Goal : to contribute to sustainable improvement of the economic status of poor women in the cities of Porto Novo and of Cotonou and its outskirts through better control of the financing of their activities .
- ✓ Membership : 30.000 women (2004)
- ✓ Network: 112 savings and credit associations (SCA) and 26 savings and credit funds (SCF)

AssEF's Health Micro Insurance goal

- ✓ To secure women's financial and economic situation
- ✓ To secure AssEF's credit portfolio
- ✓ To offer a new service in a highly competitive context of MF

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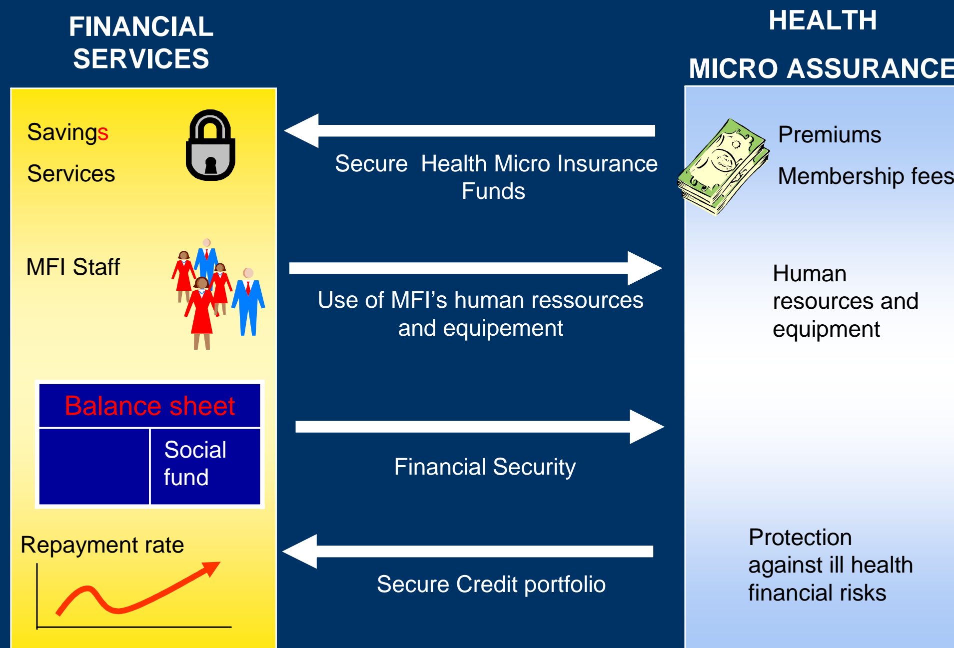
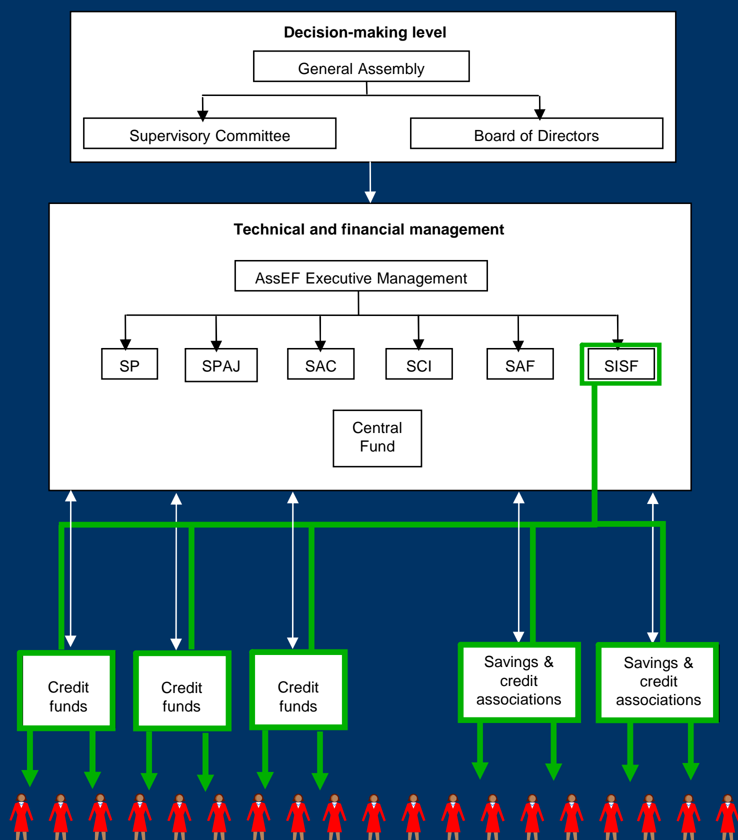
Specific objectives of a health micro insurance linked to micro finance activities



The characteristics of Assef's Health micro insurance

- ✓ Feasibility Study carried out in 2002 /2003
- ✓ Target population : 180.000 inhabitants in Cotonou and outskirts
- ✓ Start up of HMI's activities (enrolments) in May 2003
- ✓ Health Micro Insurance is considered as a new activity of AssEF
- ✓ Premium : 400 CFA F / beneficiary / month
- ✓ Coverage : 70% (Outpatient treatment and hospitalization, uncomplicated and difficult deliveries, laboratory tests and generic drugs)
- ✓ Contracted health care providers network : 5 Health centers and 2 reference hospitals in Cotonou



Distribution

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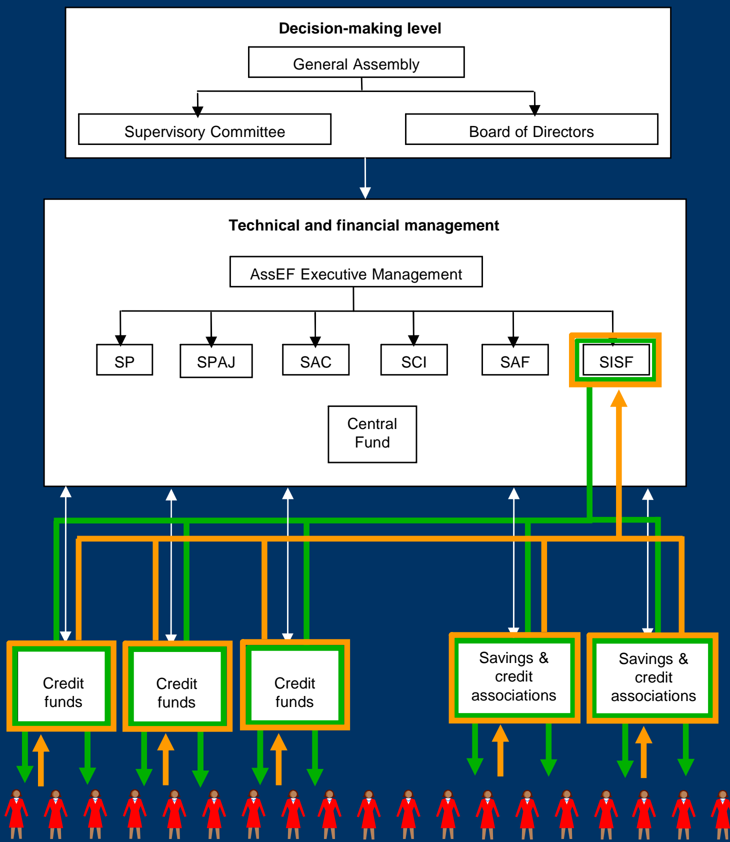

Distribution

Enrolments

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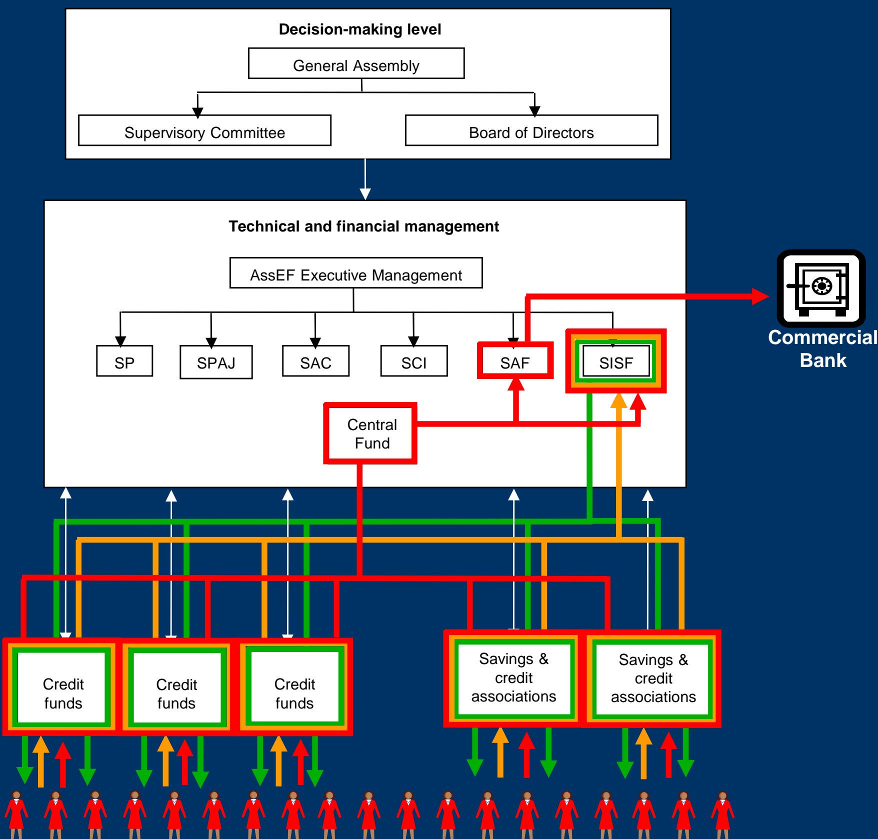
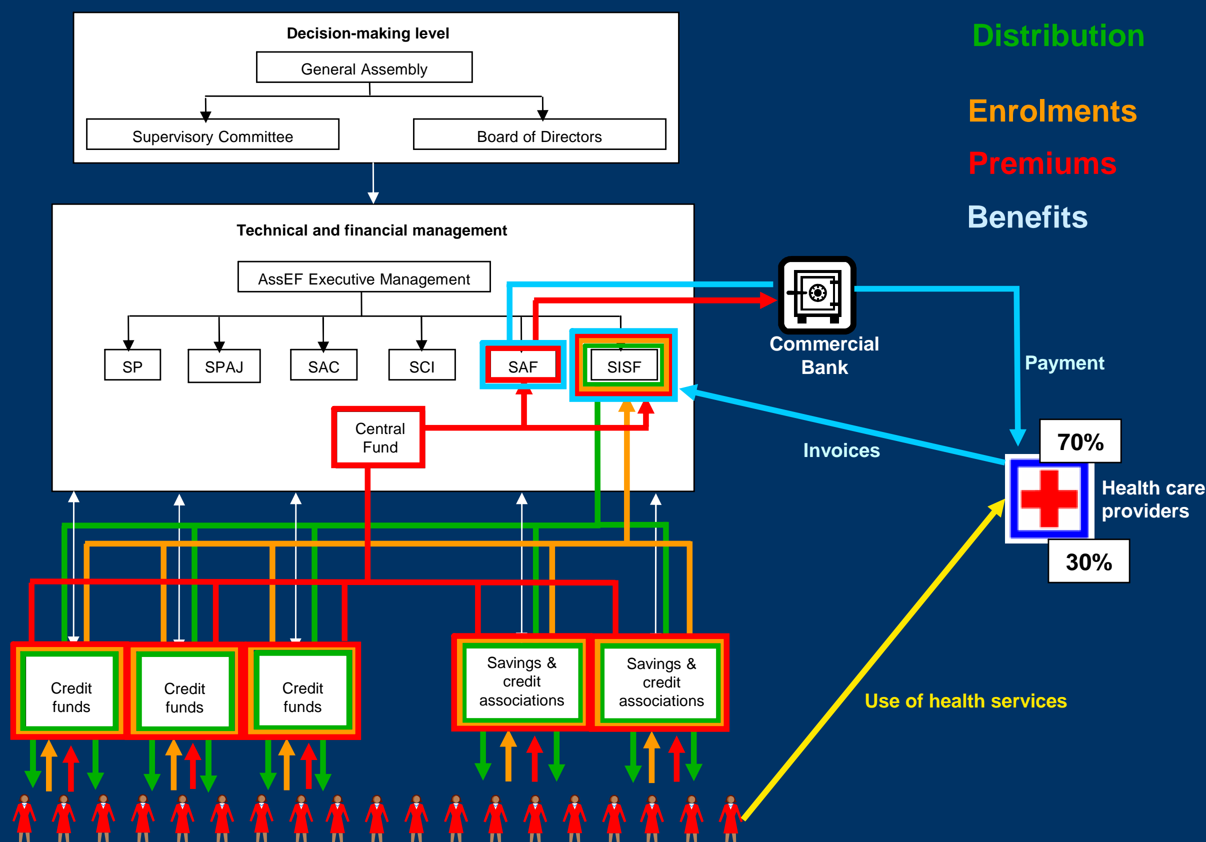


Distribution

Enrolments

Premiums



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Major breakthroughs

- ✓ **Substantial protection against ill health financial risks**
  - ➢ 70% coverage of health care expenditure at primary and secondary health care levels; cost-sharing of 30%
  - ➢ Focus on specific needs of women and children
  - ➢ Both visibility (primary level) and protection against major risks (secondary level including surgery, hospitalisation)
  - ➢ The partner HC providers deliver not only generic medicines but also specialties and brand-name medicines, which allows to provide an appropriate (and relatively comprehensive) coverage of medicines, without being compelled to negotiate with private pharmacies
  - ➢ The users, members of the HMIS, express their satisfaction during periodic self evaluations of the scheme
- ✓ **Premium lower than its real cost :**
  - ➢ In 2004, the real cost per beneficiary registered is 619 CFA F/month
  - ➢ Each beneficiary pays 400 CFA F / month
  - ➢ The gap is financed by the savings done on the probation periods and through the coverage by AssEF of hidden operating costs (such as premises and staff)

Major breakthroughs

- ✓ The HMIS system is simple and manageable for an organisation that does not have prior health insurance skills
  - ➢ Simple technical management mechanisms
  - ➢ HMIS tailored to and uses the MFI network and structures
  - ➢ STEP technical support : training and software tools

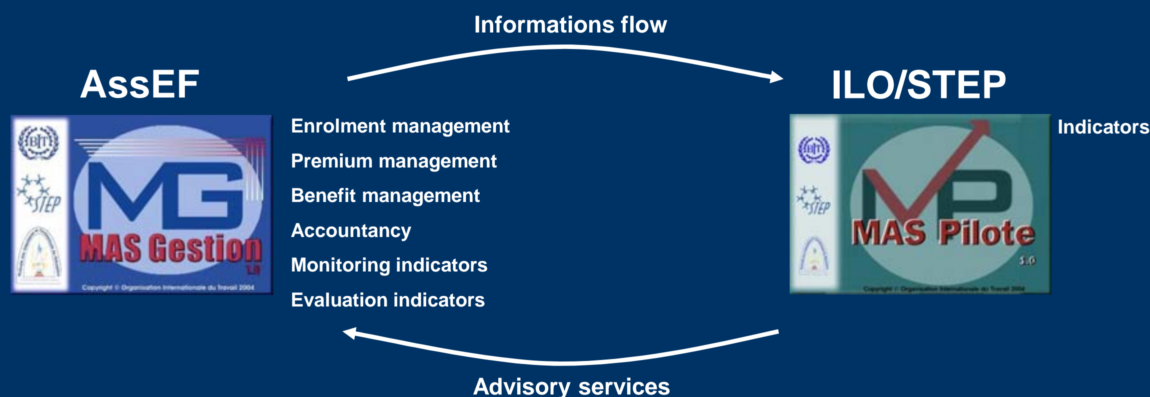
Major breakthroughs

- ✓ Simple claims mechanism for the beneficiaries
  - ➢ Mutual health insurance societies principles : no risk selection
  - ➢ Direct access to partner healthcare providers on presentation of the membership booklet
  - ➢ Financial accessibility improved : the patient pays only 30% of the expenses as co-payment (cost-sharing)
  - ➢ Geographical accessibility : priority given to the creation of a network of healthcare providers covering Cotonou and its outskirts to ensure vicinity between housing and health centers

Major breakthroughs

✓ **Ongoing monitoring system**

- Use of a software "MAS Pilote", which helps to monitor a set of 11 indicators, namely : enrolments, premiums , benefits, consumption , average cost of services and average spending by beneficiary.
- Technical management improved by the implementation of a management software including ongoing monitoring and evaluation functions of the HMIS



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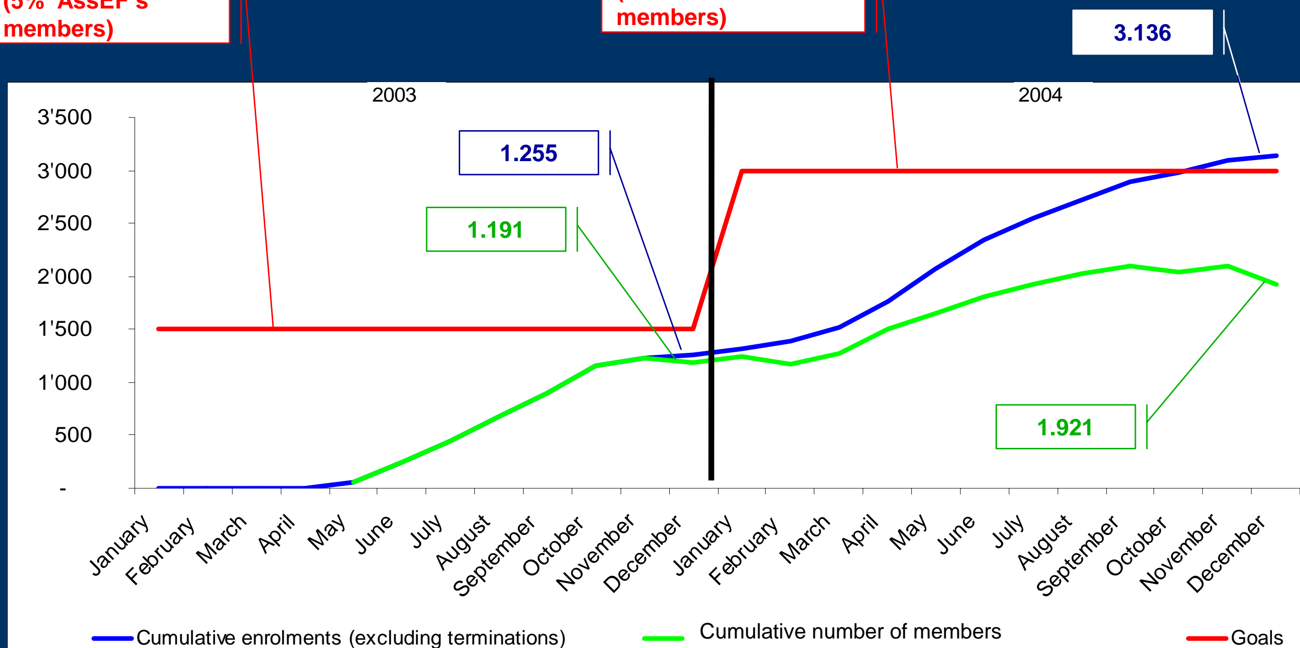
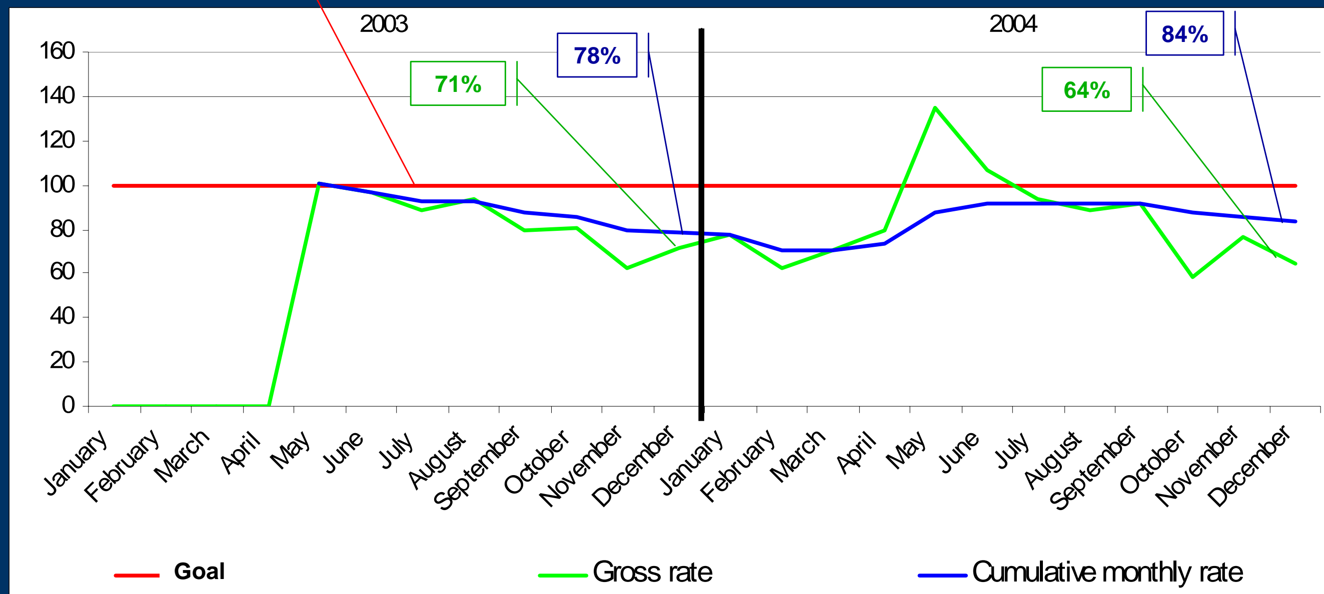
Evolution of membership



Premiums collection rate



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Evolution of the system

- ✓ Conclusion : The system does not develop as expected
- ✓ Internal factors
  - ➢ Experience in adjustment phase
  - ➢ The HMIS needs to overcome some reluctance
  - ➢ Low household coverage
- ✓ External factors
  - ➢ HMIS is operating in an environment not very conducive (no status, individual negotiation with healthcare providers,…)
  - ➢ Sudden disruption of its environment

Major Challenges – Internal constraints

- ✓ HMIS is in adjustment phase :
  - ➢ Test period of financial and technical feasibility elements
  - ➢ Learning process for several key actors within AssEF
  - ➢ Tuning of relationships with healthcare providers

Major challenges – internal constraints

- ✓ HMIS is new and needs to overcome some reluctance
  - ➢ Insurance suspicion and lack of risk management strategies
  - ➢ Women income is low and irregular; they give priority to their day-to-day expenses. In such circumstances, women are not motivated to pay for protection against risks that are uncertain even if they are fully aware that ill heath risks are a real financial threat to them, their family and business.

Major challenges – internal constraints

✓ Low household coverage

- Household coverage average size in the HMIS is 1,1 person (6 in the target population)
- Possible explanations :
  - Women are limiting the number of dependants to pay a lower premium
  - Mistrust : The enrollees are "testing" the HMIS product before contributing for the entire household
  - Adverse selection
  - Wrong message : awareness raising oriented more on women enrollment than on household coverage

Major challenges – external constraints

✓ HMIS is operating in a environnement not conducive

- No legislation on MHI
- Health care supply which is unappropriate
- AssEF is left to lead negotiations with HC providers all by itself (no support from contractual framework, federation of schemes, etc.)

Major challenges – external constraints

✓ Abrupt disruption of the nearby environment

- HMIS is directly depending on the MFI network performance
- AssEF Micro Finance network was strongly disrupted by the MF crisis in Cotonou (highly competitive sector)
- The problems encountered in MF activities had a negative impact on MHIS; resulting in a halt in enrollments development

Major challenges – proposed solutions

✓ Recovery plan for microfinance activities, initiated by AsseF

✓ Simultaneously, HMI consolidation plan based on :

- Focusing microinsurance consolidation on the most active savings and credit associations and credit funds
- Stronger premium collection
- Adaptation of management rules governing entitlement to benefits
- Communication plan with an emphasis on:

Husbands' contribution towards payment of premiums
The services offered by the HMIS and how it works

Lesson learned

✓ Selection and negotiation with HC providers

- Agreements with confessional healthcare providers who are sharing social welfare objectives
- Providing the best quality/price ratio
- Real partnership founded on mutual respect by each party of their respective commitments (contractual fees, quality, treatment protocols, …)

Lessons learned

✓ Risk management and monitoring on an ongoing basis

- HMIS has to manage scare resources (low contributive capacity)
- This implies better control of premium collection and health care expenses
- An ongoing monitoring has allowed to :
  - To assess the HMIS capacity to attain its objectives regarding enrolment
  - To test solutions to improve premium collection
  - To track discrepancies between forecasted and actual frequencies of utilization and average costs of health care services

Lessons learned

✓ Ensure that necessary management tools are in place

- AssEF HMI is based on the Health Mutual Organization principles
- AssEF chose for its HMI an organizational model taking advantage of the MFI's human resources and equipment as well as its know how regarding management

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Remaining issues

✓ Would the HMI have resisted better to the MF crisis had it been organized as an autonomous organization ?

- Yes … the HMI could have kept certain members who left the MF network
- But … the HMI would remain dependant upon the funds and associations for its diffusion and the collection of premiums