International Labour Office

HMIS in National Social Protection strategies

Experiences from francophone African countries

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Background information

International Labour Office

- Some figures:
  - Only one in five people in the world benefits from adequate social health protection
  - Out of the 10 million children that die every year under the age of 5, 50% die in Africa
  - In Africa, 47% of the population lives with less than 1 dollar per day
  - In sub-saharian Africa, only 5 to 10% of the active population is covered by an health insurance
- Lack of coverage concentrates in
  - Informal economy and rural areas;
  - Where insecurities are the highest.

Microinsurances' first steps (90's)

Founding principles:	- mostly community based HMIS -Need to be self-financed from day one - Need to adapt management capacities to limited financial means
Description:	- Voluntary membership mainly, low premiums providing a reduced HC package
Development type:	Bottom-up
Examples:	HMIS Thies Senegal, rural HM Burkina, Mauritania, Mali, …
Gains:	- MI are able to offer an understandable basic product - participation of civil society in the design of schemes, social control. - improved conditions of access to health care and reduced insecurity - On the healthcare provider side, increased transparency in billing setting
Hindering factors:	- Beneficiaries' limited contributive capacity -Weak management often based on voluntary work, poor information systems. - reduced pooling systems , low collection rates - weak capacity to negotiate with HC providers
Lessons learnt:	- Need to implement performant management system (for practical and trust matters) & to manage efficiently scarce resources - Find alternatives to strengthen beneficiaries' limited contributive capacity.

Focus on some African countries' new approaches

Senegal : - PAMECAS (Linking Microfinance and Health Microinsurance)

- TransVie, Social mutual organization for workers of the transportation sector.
- National Social Protection Strategy

Benin : MSS, HMI for craftsmen and workers of the informal economy

Burkina Faso : Communities and National Health Insurance schemes

Rwanda : Mutual Health Organization National scheme

DRC : HMI based on socio-profession groups.

→ Questionings brought up in the building up of these schemes…

To cover or not to cover?

	Advantages	Disadvantages
From the insurer's point of view: Cover low frequency/high-cost events	Coverage of high-level risks with low contribution	Low to very-low insurance visibility
The insured's needs: Frequency of small risks Need to access the health pyramid	Good visibility Early use of HC	High premium amount, more complex management, subject to fraud
ILO and national health policies: Promote access to healthcare to All		

Insurance products need to find an equilibrium between different points of view. To do so, systems include:

- Healthcare providers supplying the best value for money (generally public and confessional healthcare providers)

- Generic medicines

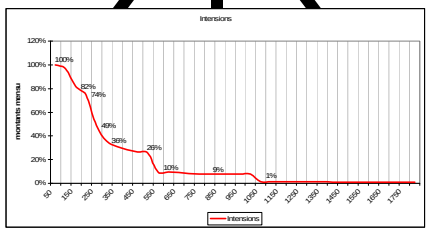
Objective : Cover a basic healthcare basket

Where to find the right equilibrium...

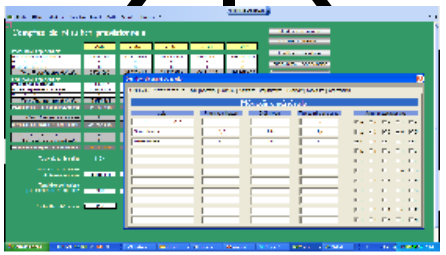
… between willingness to pay and premium amount?

Monitor the product's sustainability

IT system



Household surveys to measure willingness to pay



Scenarii with target groups (computerized information)

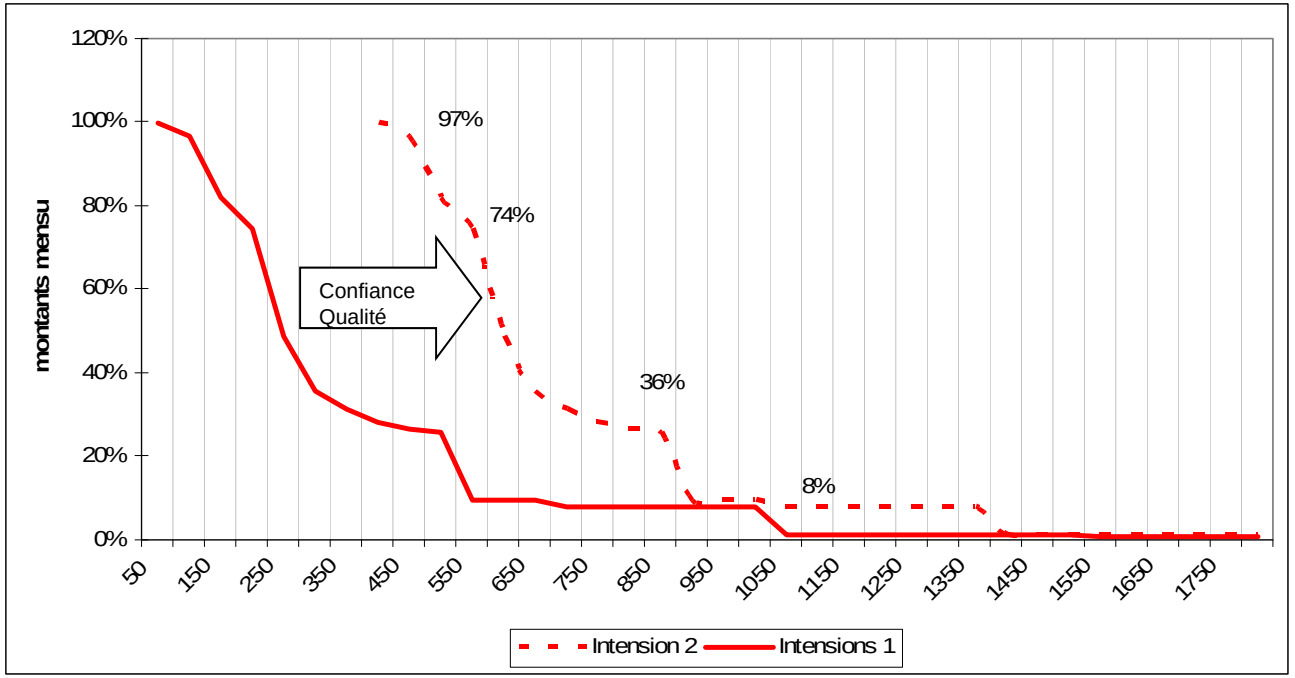
Where to find the right equilibrium…

between willingness to pay and premium amount?

Lessons learnt from the MSS in Benin :

The amount that members are willing to pay depends on:

- their contributive capacity (no subsidization of the premium)
- **trust in management and perceived quality of insurance product**

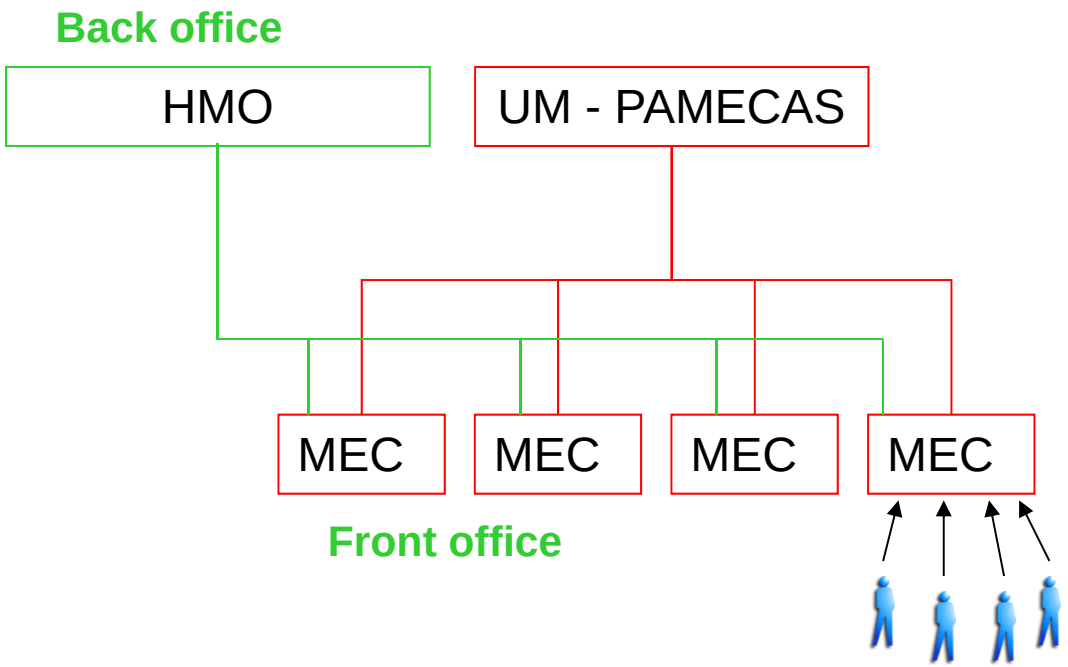


Which distribution channel to choose?

Choose distribution channels that allow reaching a great amount of beneficiaries

PAMECAS :

Use of a MF network to spread the insurance product



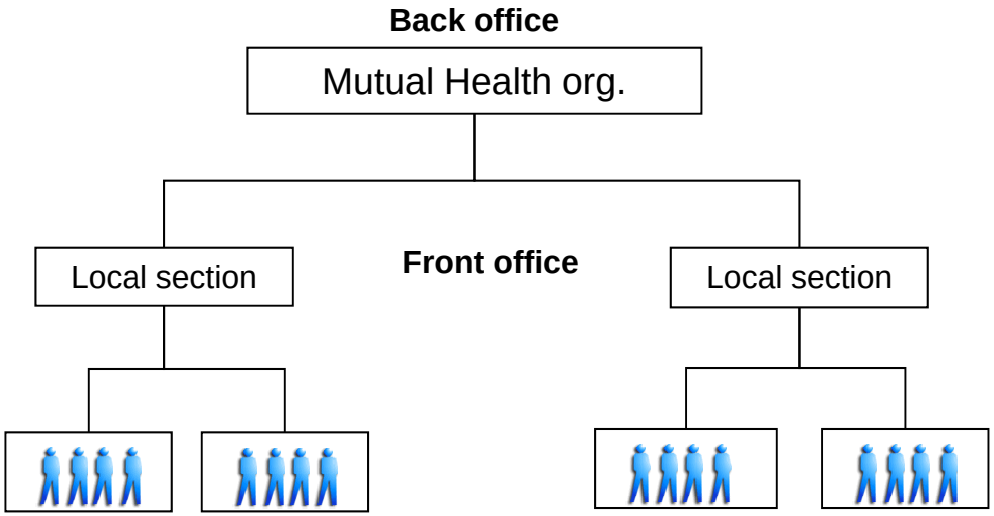
Which distribution channel to choose?(cont.)

Choose distribution channels that allow reaching a great amount of beneficiaries in the informal economy

TransVie and MSS :

Distribution of product by workers' groups (GIE, micro enterprises, etc.)

National mutual organizations represented by local sections



Voluntary or mandatory?

Rwanda : Mandatory , pilot programs in 3 districts in 1999, mandatory for every Rwandan family, rural and urban since 2004. MHI card required to put children to school , administrative documents required to get married, etc.

PAMECAS : Voluntary , on-going questioning on linkages between access to credit and membership to a HMO.

TransVie : Voluntary (process started with MFI from the transportation sector to make MHO mandatory for credits contracted to buy cars, same for economic group membership

MSS : Voluntary for workers' groups
Automatic in micro-enterprises.

Difficult to make it mandatory for the informal economy (How to constrain people ?)

Alternative : make membership as attractive as possible

How to promote the development of professional schemes ?

TransVie	Burkina Faso
1. Focus put on the system management: more professional, IT system, hired personnel, well-equipped offices, sensitization, communication & Information to target population, social marketing, etc.	
2. Healthcare basket covered is large enough to answer needs and cover high-level risks.	
3. High premium ($24 / month for a 6 person hhs) but shared between : – Employers1/3 / workers 2/3 – Members / Groupings (social practices)	3. High premium but shared between: – Employers / workers – National social transfers, international solidarity
4. Development and financing plans that include subsidizations of fixed and operating costs until enabling good managing capacity from the start (low amount of beneficiaries). When extreme poverty (rural), the health budget can be subsidized.	

New approaches' first results

A significant impact on several aspects:

- The number of people covered: Socio professional based systems are able to reach more than 10.000 beneficiaries in 2 years with a continuous and mastered growth.
- MHO Rwanda : enrolment rate from 33% in 2004 to 84% of the population in 2008; utilization rate of HCS from 33% en 2004 to 66 % in 2007
- Accessibility to a large health basket (primary and secondary HC) covered by the HMIS
- Improved collection rate (+80%)
- National social protection strategies include and support the systems.

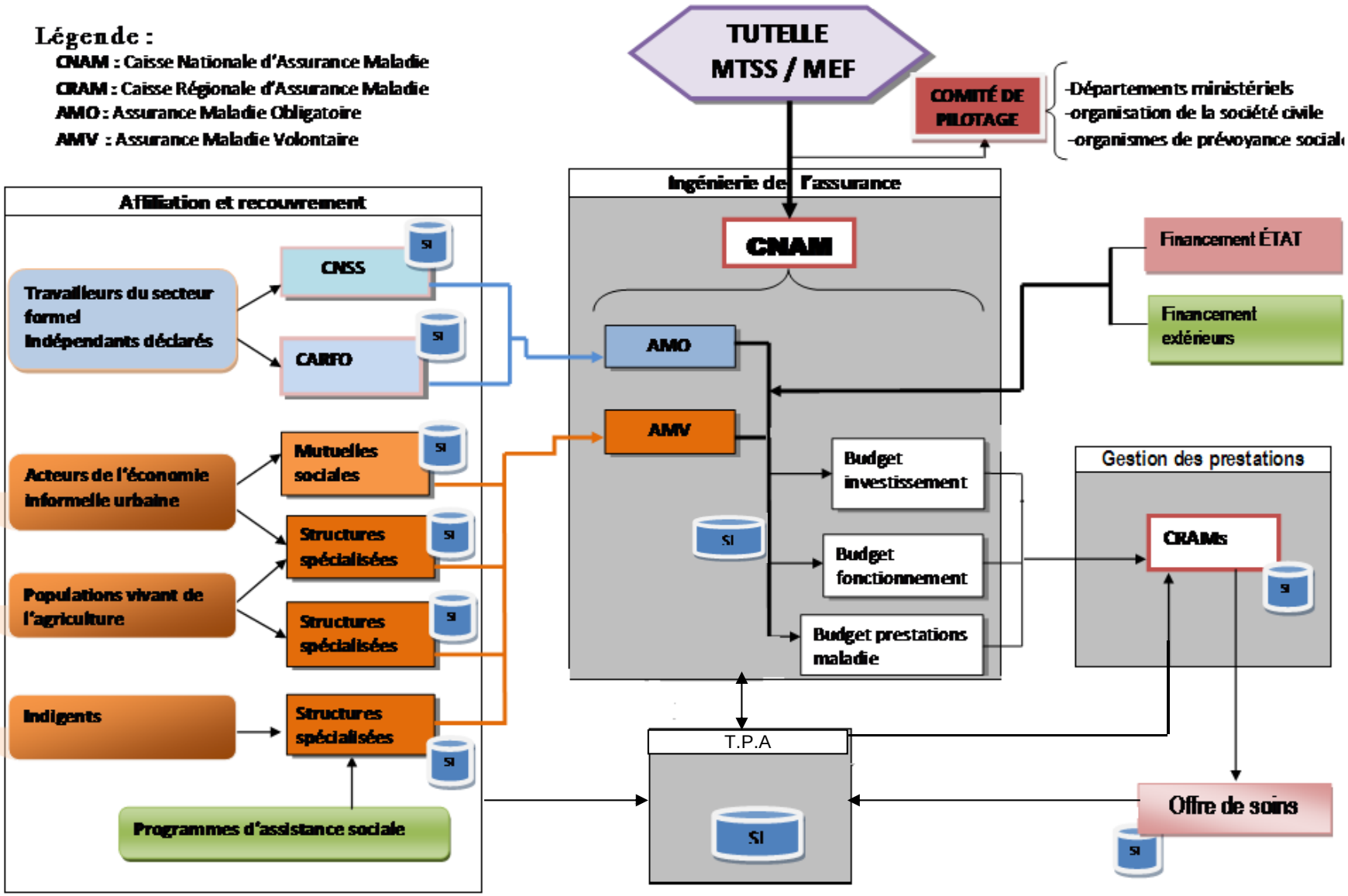
But they still face a great number of challenges:

- No legislation
- Difficulties in contracting with healthcare providers (information asymmetry)
- Low raising of external funds and social transfers. HMIS are currently self-financed

2008 : Way forward

- Passing of the Law on social mutual organizations by UEMOA (WAEMU) .
- National framework for contracting with healthcare providers (Senegal)
- National health insurance scheme in Burkina Faso

Burkina Faso : Health insurance for All



Burkina Faso : Health insurance for All

Principles given by the State

- National solidarity: Contribution depending on incomes.
- Equity and equality of treatment: Possibility given to all to access and benefit from services of quality.
- Diversification of tools and actors: mix of instruments adapted to insurance
- Membership and collection mechanisms adapted to different socio-economic categories.
- State's general responsibility to guarantee the right to social protection and to enforce contributory obligations for each individual.
- Democratic management : Participation of beneficiaries in governance

National and international social transfers

Use of new technologies:

- IT systems
- Use of NICT for a better fluidity of information and to make the scheme easier.