Micro-insurance and Health Care in Developing Countries
An International Picture

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The concept of solidarity-based banking and insurance lies behind the Belgian Raiffeisen Foundation’s (BRS) work in developing countries. The BRS provides support to various cooperative savings and loans organisations through advisory services and funding initiatives.

Insurance is clearly taking hold, and this has inspired the BRS to channel more of its efforts into this activity. In this context, our organisation is occupied on two fronts: on the one hand, with insurance products linked to savings and loans activities and, on the other, with dedicated mutual health insurance systems (mutual health care services). The core objective behind the work of the BRS is to promote cooperation and create synergies. This publication is the result of a BRS seminar organised in 2003 with the help of several specialist Belgian organisations. For the BRS, this seminar was a defining moment for all future cooperation work.

I wish you much reading pleasure.

Rik Donckels
BRS Chairman
The organisation and provision of health care is an intractable issue for a great many people in development cooperation. Many developing countries still have very little in the way of an established health care system with enough doctors and nurses, dispensaries, hospitals and pharmacists for all. Where these services do exist, they tend to be under-used by the local population. In recent years, people have addressed some of these problems by setting up organisations known as micro-insurance institutions. These organisations bring together the local population and make sure that they insure themselves against the risk of becoming sick. The term ‘micro’ is used because the cash contributions paid by affiliated members of the local micro-insurance institution are small. Such institutions do more than simply pool the financial resources of local people. They negotiate with medical personnel to establish the quality of health care provision, and provide their members with information and advice on a whole range of health care issues.

In this brochure, we describe how micro-insurance institutions can fit into the local health care situation and say something about the role they have to play. We also look at the various obstacles standing in the way of anyone who wants to set up and operate an organisation of this type.

Much of the information we present here is taken from a seminar entitled ‘Mutual Health Insurance – in Search of Success Factors Learned Through Belgian Field Experience in Developing Countries’, hosted on 9 October 2003 by the Belgian Raiffeisen Foundation, the Centre for Social Economics of the University of Liège, Higher Institute for Labour Studies of the Catholic University of Leuven, Belgian Technical Cooperation and the Directorate General for Development Cooperation.

Patrick Develtere
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1 INTRODUCTION

Every human being has a fundamental right to basic health care. And yet access to health care is restricted for the overwhelming majority of the population in developing countries: people are too far away from the nearest health centre, there are not enough doctors and nurses, the centres lack the basic equipment and medicines needed, and the service provision and bedside manner leave a lot to be desired. The patients often have to bear the costs of treatment themselves, meaning that low-income families are sidelined.

After independence, many of the governments in the former colonies tried to provide free (or highly subsidised) basic health care for their country’s population. In so doing, they modelled their attempts on the ‘welfare state’ examples of the industrialised world. In the poorest regions, however, it didn’t take long for these attempts to go astray. There were several reasons for this. The most important factor was that the health care infrastructure wasn’t growing fast enough. The population was expanding quickly and the health care services were unable to keep up. At the same time, the countries’ leaders didn’t have the financial means to set up and sustain an extensive health care system and pay the salaries of the health care staff. In financial desperation, a lot of countries turned to the World Bank and the International Monetary Fund (IMF) for (more) loans. These institutions lend money with a view to helping developing economies to their feet, and one of the lending conditions is that these countries cut back on spending. Unfortunately, health care is generally one of the first areas earmarked for cutbacks.

Against the backdrop of this downward spiral, the World Health Organisation (WHO) and Unicef launched the Bamako Initiative in 1987. This initiative was designed to secure access to quality basic health care for the population as a whole. The Bamako Initiative rests on three central principles. The first is the concept that health care services must be self-financed. This means that the patients themselves pay towards their health care (through ‘user fees’). The second is the principle of better access to medicines. The choice fell on the side of generic medicines, rather than the more expensive brand names, and basic medicines (needed by the majority of the poor population) instead of specialised medicines (generally for the elite). Primary health care centres sell generic medicines only, and secondary health care centres encourage the use of generic medicines as well. The third principle is that of community participation. If representatives from the local community are encouraged to sit on the managerial boards of the health care centres, this will make them more democratic and transparent.

Many developing countries endorse the principles of the Bamako Initiative and have readjusted their health care policies accordingly. However, it hasn’t been plain sailing. In almost every country that adopted the Bamako Initiative, management and/or health care boards were set up in the health centres and run by people from the local region. A marked rise was noted in the quantity of generic and basic medicines available. However, there was...
no real improvement in access to health care. In fact, access deteriorated in many countries.

Asking patients to pay for health care services increases the financial threshold. The contributions charged in government clinics, private hospitals and by pharmacists are simply too high for many to pay. Therefore, they use the health centres less, they put off seeing a doctor when they become ill, or they only follow part of the recommended treatment.

This withdrawal of free access to health care services has taken away an important layer of social protection from a large segment of the population. It was high time, therefore, for alternatives to be found. One of the more promising solutions comes in the form of the micro-insurance institutions. If people are brought together in a mutual insurance institution, a financial pool that can be used to cover (part of) the medical expenses of the organisation’s sick members. In this brochure, we will first look at the place and the role of the micro-insurance institutions.

We will then go on to discuss the various steps involved in setting up an organisation of this type. Thereafter, we will give a critical appraisal of the advantages which this organisation offers its members and the health care system as a whole.

In the final chapters, we will deal with the various obstacles likely to be encountered when setting up, running and supporting a micro-insurance institution.
Micro-insurance by any other name...?

There are many terms used to describe these new health care initiatives. Many countries talk about mutual health care services or health service funds. In other places we hear the terms ‘voluntary’ or ‘community health insurance systems’. Others still, refer to mutual insurance initiatives.

The International Labour Organisation (ILO) coined the term ‘micro-insurance’ in 1999. This term describes the characteristics common to a rich diversity of initiatives. They can, of course, vary from case to case due to the different organisational models they are based on. Obviously, the term ‘micro-insurance institution’ refers explicitly to micro-finance institutions, as popularised by the example of the Grameenbank in Bangladesh.

Technically, however, the term ‘micro’ is not a reference to the size or scale of these organisations and institutions. Some institutions have a base of tens of thousands of members. The term ‘micro’ refers to the small transactions on which these organisations are founded. What makes the micro-insurance institution special is that its members make only relatively small financial contributions. Secondly, the term refers to the proximity, or short distance, between the members and the institution. Just about all of the initiatives have these two dimensions in common.

There have been comments from several corners suggesting that the term ‘micro-insurance institution’ over-emphasises the insurance aspect.

Many, but not all, institutions are distinguished by their non-profit based nature, their reliance on participation, and their underlying mechanism of solidarity. This is why many people prefer the term ‘mutual health organisation’.

In this paper, we use the term ‘micro-insurance institutions’ because in the majority of countries in Africa and Latin America they are separate institutions or organisations. Nonetheless, at times we might refer to ‘micro-insurance systems’, which tend to be incorporated in the activities or services of existing organisations. This is the predominant model in Asia, and it is becoming more current in Africa as well.
Below, we suggest a few strategies to enhance social protection, and take a more detailed look at the place of the micro-insurance institution in the health care system.

2.1 Potential strategies for social protection

Employees with permanent careers in formal (private and public) sectors are usually affiliated to some social security system or other. The state or the employee contributes to a social security fund to which members can appeal whenever they need health care services. However, estimates tell us that in many developing countries these systems cover only about 10% of the population and that the protection they offer such employees tends to be fairly crude. They only cover the costs of a limited number of treatments and services. Some reasonably well-off developing countries have been attempting to extend this system and that of compulsory social security to new target groups. Along with employees from businesses in the formal economy, they are taking on small entrepreneurs or workers from the informal economy. For the majority of developing countries, this is not a feasible proposition because they have neither the resources nor the administrative infrastructure to collect the contributions.

There are private insurers in many countries. In the countries of the developing world, these insurers tend to focus on the traditional risks, such as accident and fire, but as time goes on they are developing more and more health insurance products. Naturally, the private insurer aims to make a profit, so he will take every precaution to ensure this. The client pays a premium commensurate with the risk he runs. Extending this principle to health insurance, we see that the elderly and the chronically sick will be forced to pay much higher premiums than the young and the healthy. A system of this type excludes a vast section of the population and its clientele is made up almost exclusively of the wealthier high and middle classes.

Some places operate informal insurance systems in which the members of a group contribute a fixed sum on a regular basis. These solidarity groups usually consist of members of the same tribe, local residents, or members of church communities, and they agree upon the contributions between them. The funds are collected on a weekly or monthly basis, as and when the group meets. The ‘pot’ is set aside for members of the group who are (unexpectedly) faced with a major expense of some kind, such as a funeral or an operation.

Families on every continent of the world set up systems to cement solidarity between their members. If one of the family members becomes sick, the other members are morally obliged to step in and lend a hand. The wealthier individuals contribute more than those who have less to give.

Up to now, the systems of social protection we have been describing provide a safety net for some in
the event of sickness, accident or childbirth. What they don’t do, unfortunately, is offer protection for everyone. Only a few people have access to the official social security system.

For many, the premiums charged in the private insurance sector are too high. If people are chronically sick, they won’t even have access to the informal insurance system because they use up more of the funds than they contribute. If people move to the city, leaving their old life behind them, they will no longer be able to rely on members of their family for help. As a result of this, many people fall through the net.

The question is: How do micro-insurance institutions tackle problems of this type?

2.2 What exactly is a micro-insurance institution?

There are several types of micro-insurance institutions in the field of health care. The best way to start is by describing the things they have in common.

The sharing of risks offers social protection

A micro-insurance institution protects its members against the financial difficulties imposed by health problems, and it does so by pooling the financial contributions of its members and spreading the health risks between them. If its members share the risk, this provides a level of social protection. This sharing of the risk varies in degrees, and is at its highest when the members include old people as well as young people, and healthy people as well as sick people.
The members’ contributions keep the system going

Micro-insurance institutions operate by using the financial contributions of their members. They may also receive partial funding from the government or from donors. However, what is really important here is that they remain financially independent of this external support.

A micro-insurance institution tries to maintain the ideal balance between its members’ contributions and the benefits it pays out. The higher the collective contribution, the more of its members’ expenses it can cover.

The initiative takers who set up the micro-insurance system try to fine-tune the contributions to suit their members’ budgets and the buying power of the local population. In many cases, they make allowances for the seasonal or time-specific character of their members’ earnings and try to collect the contributions after the crops have been sold, or on market days, for example. Situations vary, and they may ask for monthly, six-monthly or even annual contributions.

A key factor in any micro-insurance institution is that the premium doesn’t reflect the risk, but the service provision. When they start out, most of the institutions ask everybody to pay the same premium.

At a later stage, they are able to offer packages in which members choose a formula and pay a corresponding premium. The basic premium gives entitlement to a basic package of services while an extra premium secures extra services (e.g. transport to a hospital).

Membership is voluntary

Theoretically, people can join a micro-insurance institution freely and leave at any time if they so desire. At the end of the day, anyone who accepts and follows the rules of the organisation can join. However, membership can take on a less voluntary dimension at times. This may be the case, for example, if another organisation is providing health cover for certain individuals. A trade union might offer a package of services, and anyone who joins the union also joins the health care system.

In practice, there are several selection mechanisms in place. People who organise themselves to set up or join a micro-insurance institution usually have several characteristics in common. For example, they might be members of the same association, or belong to the same ethnic or religious group, or all live in the same village, or all do the same type of job. This generates a sense of social cohesion or togetherness among the group, which can have a positive effect on the micro-insurance institution.

It is much easier for people to share risks and pool resources if they know each other or come from the same group. It is also more difficult for members to abuse the system or miss payments without the others having something to say. Participation in the micro-insurance institution will be better if its members are linked in some way.

A micro-insurance institution is a not-for-profit organisation

Micro-insurance institutions focus on service provision, not profits. However, this doesn’t release them from the need to strike a financial balance and sustain a proper level of financial health. A positive financial result is actually desirable. The institution...
doesn’t distribute profit as a cash dividend among its members, but uses it to build up a reserve, or to lift service levels and improve the quality of service provision, or reduce its members’ contributions.

**Member participation and control**

No micro-insurance institution can function properly unless the activities or services it offers satisfy the needs of its members. Not only that, but its members must have confidence in the care providers and the people who run the institution. That is why it is important for the institution to involve its members actively in the way it is run. In most cases, it will invite its members to the annual general meetings. As the institution’s most important decision-making body, the annual general meeting decides on matters such as budgets, accounts, what to do with surpluses, and matters of overall strategy. The annual general meeting usually appoints the health centre’s directors and managers.

**2.3 The players involved in operating micro-insurance institutions in the health care field**

For many years, the government and the medical corps were the only parties involved in the health care systems. Since patients (or the population in general) were a relatively passive group, the demand for health care was not particularly strong. Supply did not always coincide with demand. Micro-insurance institutions can help re-establish the link between supply and demand. The impulse to organise the ‘demand side’ and to establish an institution can originate from patients or from groups of the population themselves. At the present, however, most of these initiatives come from elsewhere. Below, we look at the players involved and try to pinpoint their particular interest in micro-insurance, as well as the role they can and do play.

**The government**

In most countries, the government is the primary party responsible for health care provision and health care funding. This usually involves input from two ministerial departments: the Ministry for Health, which puts in place and maintains a large-scale public health care system, and the ministry in charge of social security or social protection (often the Ministry of Labour and Employment), which funds the medical services used by those working in the formal sector. In many countries, the government’s role may be less executory and more coordinating in character. In developing countries, the ministries of Health and Labour encourage initiatives on the demand side, such as micro-insurance organisations, and attempt to incorporate them in the health care system. In so doing, they are attempting to make up for the lack of social security and social protection available to people who earn a living in the informal economy.

The government often plays a dual role. On the one hand, it uses all kinds of promotional initiatives to encourage the population to set up micro-insurance institutions, while on the other it lays down the rules and regulations by which these institutions operate. In some countries, for example, there are laws governing how such an institution can be set up, the services it can provide, and the methods of control and supervision.
The care providers

In certain places, the care providers are the driving force behind micro-insurance institutions. They are aware that up-front payment systems and other risk sharing mechanisms are likely to increase the extent to which their health care services are used and also know that this increased usage can bring in regular or extra funds for the health centres. This makes the centres more viable from a financial viewpoint, and makes them less dependent on (fairly irregular) state subsidies and private donations.

These are the main reasons which explain why the care providers themselves take the lead in setting up micro-insurance institutions. In addition, in many cases these care providers play a leading role after the institution has been set up. They sit on the management board, provide staff to see to the institution’s administrative needs and provide logistic support, such as rooms and transportation.

Care providers also feature prominently in micro-insurance institutions, though they themselves may not be the initiative takers. For example, they may attend the board meetings of the institution, or, in many cases, conclude contracts with the institution. These contracts specify the rates and the quality of the care provided, as well as the methods of payment and the consultation mechanisms. It is crucial to any micro-insurance institution that the care providers be involved to this extent. After all, the institution’s success will rest on a good understanding and appreciation of the rules. Without these rules, for example, the care providers run the risk of over-prescribing (see further).
Below are several examples of micro-insurance institutions that were set up by care providers:

**CDI Bwamanda**

In 1986, the Centre de Développement Intégral (CDI), a local NGO in Bwamanda in the equatorial province of the Democratic Republic of Congo, started up a health plan of its own. The CDI is active in several areas, such as coffee production, education, road building, drinking water and health care. The CDI’s hospitals and dispensaries make it the leading care provider in the region. About 50% of the population (more than 72,000 people) are beneficiaries of the ‘mutuelle’. The membership subscriptions are processed and the contributions are collected in the period when the coffee harvest is sold, which is when the people have a little more money to spare. Membership is open to anyone who lives in the district of Bwamanda and subscriptions always cover entire families.

To take the strain off the hospital services, patients are referred through a basic health care centre. These patients make a 20% contribution to the costs, and the micro-insurance institution covers the remaining 80%. It keeps its accounts separate from the hospital’s accounts. To preserve the purchasing power of the organisation’s financial reserve and offset the effects of inflation, the subscription fees are managed by means of an investment policy.

This system of payment in advance guarantees that the financial resources will be there to keep the hospital running. As it now stands, resource availability has doubled and access to hospital care has improved. This persistent pursuit of quality health care and access to it over the years has built up a relationship of trust between the population and the medical services.

The patients pay for the primary health care themselves in the form of a fixed consultation and treatment fee.

The population has been actively involved in every phase of the health insurance system: choice of model and organisation as well as implementation and control. Further actions by the NGO are designed to stimulate participation in the project.

The day-to-day business of the mutual health care service is handled by the hospital’s subscription and invoicing department and its finances are supervised by CDI Bwamanda’s accounting department.

The local authorities, the CDI services and the local population are all represented at the annual general meeting.
Gonoshasthaya Kendra (GK)

GK is an organisation of doctors and medical personnel which was set up in Bangladesh in 1971. Alongside its extensive network of hospitals and village clinics, GK has set up a medical school and a factory producing medicines. Not only that, but GK is setting up micro-financing institutions in the villages. These units make it possible for the villagers to take out small loans. In the mid 80s, GK introduced its first micro-insurance system for health care services. More than 550,000 people from 353 villages are involved in GK’s projects. In 2001, 149,008 families were affiliated to the micro-insurance institution. These people are divided into three categories: poor, affluent and rich. The premium they pay into the institution depends on which category they fall into. Members have access to health care and medicines at a lower price than non-members. Preventive health care (such as vaccinations) is free. Although GK organises the system from the centre, the village clinics and hospitals enjoy a high degree of autonomy. In every health centre, there is a collection box and the centre spends the money collected in this way on care for the poorest members of the population who are unable to contribute to the micro-insurance institution.

Bangladesh Rural Advancement Committee (BRAC)

The BRAC is a private development organisation set up in 1972. It is active in several areas such as training, self-help groups for landless farmers, and health care. In 2000, the BRAC set up a pilot project at two of its health centres, i.e. a micro-insurance institution for health care. Non-BRAC members are entitled to sign up to this micro-insurance system as well. The head of the family pays a premium based on his (or her) earnings and the size of the family. All members of the family are given a reduction on their medical expenses and pregnant women receive free medical advice before, during and after childbirth. If patients are referred to hospital via their local health centre, they are refunded 50% of the hospitalisation expenses. In the first eight months, 1,500 families joined the micro-insurance institution. The poorest of the poor are allowed to join without paying a contribution and health care is free for these people. However, they are encouraged to make a contribution as soon as this is possible.
Local non-governmental organisations and associations

For a long time, local NGOs have been present to some extent in the health care sector. In many cases, once the authorities found themselves unable to provide health care services for the population as a whole, they asked the local NGOs to lend a hand. These organisations are supported by international NGOs and as such can supply a little extra funding.

NGOs may have several reasons for setting up or financing micro-insurance institutions. Many do so because they are firm supporters of a better and fairer provision of primary health care and want to see health care services coming under a more democratic form of control. Micro-insurance institutions help lower the (financial) threshold to health care and look after the interests of the local population.

Other organisations, such as microfinance institutions, have institutional motives for setting up micro-insurance systems. When local people find themselves unable to repay a loan this can often be due to health problems. It stands to reason that if their medical care is subsidised through an insurance system they will be in a better position to repay the loan.

The patients

Due to several shifts in the health care sector, the patients are no longer just a passive group of the population. Their role changed when they were forced to pay for their health care services, and since then it has gradually grown. Several countries allow ‘consumer’ representatives to take part in the management of health care services. Inspired by the idea of giving more people access to these services, the representatives worked with the health care workers to develop a number of micro-insurance initiatives. In these cases, the health centre has remained firmly at the centre of the micro-insurance institution.

In other cases, villagers have organised themselves at the grass roots level and several have come together to set up their own micro-insurance institution in the village. Their main aim is to offer villagers the financial means needed to gain access to the nearest health care services. In cases

SEWA

The Self-Employed Women’s Association (SEWA) is a union of self-employed, low-income women working in the Indian state of Gujarat. SEWA started as a self-help movement looking after the rights of women in the informal sector and it gradually developed new services such as money lending, education and childcare. In 1992, SEWA introduced an ‘Integrated Social Security Scheme’ which covers several areas including health insurance.

This social security system is the largest system in India based on members’ contributions. It has more than 30,000 members.
like these, the institution often contributes to the costs of transporting patients and buying essential medicines. In other cases again, the ‘patients’ are members of existing local organisations, such as a women’s organisation or a farmers’ union. Many of these organisations already have a mutual solidarity fund. Sometimes, members choose a more formal model for their micro-insurance institution.

Organisations in the workplace
Employees in the formal or informal sector can set up a solidarity fund on the shop floor. The members collect the financial resources on a regular basis and use them to help members who have fallen ill or had an accident. In some cases, the employer also provides backing for this solidarity fund. As in the situations described above, many are now setting up a more formal micro-insurance institution.

Trade unions can also set up micro-insurance institutions, and we are finding more and more of them at the heart of micro-finance and cooperation initiatives of all kinds. In this way, they are attempting to increase the service provision for their members and look after their interests more effectively. In some cases, everybody who belongs to the union is automatically a member of the micro-insurance institution. The union simply adds the micro-insurance premium to its union fee and administers and runs the institution. In other cases, the institution is given greater autonomy and it collects the contributions itself. Its management lies in the hands of separate authorities.

We find examples of this type of micro-insurance institution in Burkina Faso, Mali, Zimbabwe, Argentina, Guatemala and the Philippines.

Technical assistance organisations
Organisations that provide technical assistance, such as the STEP programme (Strategies and Tools against Social Exclusion and Poverty) of the International Labour Organisation (ILO), and a few European mutual health insurance funds and local and international NGOs, do not themselves set up micro-insurance systems but provide the initiative takers with expert advice. In this sense, they can provide support for any of the players listed above. Research has shown that many of the systems set up without the benefit of technical expertise have turned out not to be viable. No micro-insurance institution can be expected to survive without technical expertise from some source. We can gain a good appreciation of the expertise needed by running through the steps involved in setting up a properly functioning micro-insurance institution (see point 3).
STEP (Strategies and Tools against Social Exclusion and Poverty) is a programme run by the ILO. There are four parts to the STEP strategy: (1) Technical assistance and promotion, (2) Research, (3) Lobbying, (4) Advice for governments.

(1) Technical assistance comes in the form of feasibility studies, technical recommendations and education on the ways and means of setting up a micro-insurance institution. STEP promotes these social protection initiatives by bringing micro-insurance institutions together.

(2) In 2003, STEP commissioned 68 study reports in 26 countries. In these reports, STEP describes and analyses micro-insurance institutions in the health care system. What types of micro-insurance systems are there? Are they financially sustainable? Do they improve access to health care for the poorest segments of the population? What is their relationship with the government?

(3) STEP recognises the role played by micro-insurance institutions in improving social protection for the populations of the Southern Hemisphere. This is why STEP sets out to convince other (international) organisations of the importance of micro-insurance institutions.

(4) STEP is helping several governments in Africa, Asia and Latin America establish a technical and regulatory framework for micro-insurance institutions.
Emergence of the micro-insurance institution in general health care in recent years can be explained by the lack of a properly functioning social security system in most of the countries of the developing world. The parties involved view these micro-insurance institutions as a new instrument of social protection. Sections of the population are able to sign up to a basic health insurance system thanks to the institution.

As we have already said, this trend was most visible during the period when governments were transferring more and more of their health care funding obligations to users.

In the international arena, micro-insurance institutions are seen as one of the ways of improving health care access for the poorest groups of the population. In this sense, the role of these institutions has been interpreted in different ways. Alongside the ILO, the World Bank is an international organisation with substantial influence for issues of this type. Each has a different interpretation of social protection.

**3.1 The ILO view**

The ILO (International Labour Organisation) is the international organisation to which the United Nations has delegated the issue of social protection. Taking its lead from several international declarations (the Universal Declaration of Human Rights,
the Declaration of Philadelphia, the International Covenant on Economic, Social and Cultural Rights), the ILO works according to the principle that every human being has a right to social protection. Since the mid 90s, the ILO has been pursuing its policy of casting a wider social protection net, and, in so doing, has forwarded a combination of strategies:

- expansion of the existing social security systems;
- giving incentives for micro-insurance institutions;
- offering free core services to broad groups of the population;
- social assistance for means-tested people who appear unable to pay for these services themselves.

The latter two strategies require governments to tap their general revenues.

The ILO takes the position that social protection systems must be designed to redistribute resources and generate solidarity between the groups making up a society.

It also emphasises the links between the various aspects of social protection.

The ILO supports the view that governments should play a central role. It is up to governments to put a system of social security in place, improve upon it, and then increase its scope.

Governments should also see to it that their system of social protection is not discriminatory and that policies are transparent and correct.
3.2 The World Bank view

The World Bank has been developing its strategy of social protection since the 90s. In that time, its development strategy for national measures for social protection has grown in stature. After all, the countries of the developing world can only hope to secure support from the World Bank if it agrees to the measures they put in place.

The World Bank emphasises that there are many instruments by which social protection can be achieved. It makes clear that the government is not the only authority that should work towards the general welfare of the population and cover the risks. Besides the government, the market and the family are important players. The World Bank interpretation allows sufficient room for instruments which are not traditionally associated with social protection policy, such as self-employment incentives. It would like to see systems of social protection adapt to the national or regional context rather than stick rigidly to Western models.

However, not everyone is pleased to see the World Bank operating in the area of social protection. Some specialists argue that the front-runners in this issue should remain the specialist agencies of the United Nations, and the ILO in particular. There is a worry that countries will only be granted loans if their social protection policies fall in line with the World Bank’s guidelines, and critics say that these conditions foster the wrong kind of social policies. Since the financial might of the World Bank gives it greater power and influence than the ILO, there is a danger that countries will no longer be able to implement a social policy appropriate to their individual situation.
4 IMPORTANT STEPS IN THE FORMATION OF A MICRO-INSURANCE INSTITUTION

Micro-insurance institutions can improve access to health care in the countries of the developing world. The players in the development arena (NGOs and international organisations, among others) are hopeful that these systems will spread in the years to come. However, setting up a micro-insurance institution is no simple matter. We list the main steps below.

In fact, there is no real need to go through the steps in this order and many systems simply build further on existing initiatives. Some of these steps can even be skipped.

4.1 Contact

The initiative takers involved in the micro-insurance institution contact other, existing micro-insurance institutions and experts in the national and international support organisations.

In this way, they gather important information and learn from the collective experience of these institutions.

4.2 Information and awareness-raising

At the start of the project, the initiative takers try to enlist the support and involvement of the region’s leading authorities. This might include the local authority, traditional leaders, religious leaders and other respected members of the community.

It is very difficult to convince the population of the importance of micro-insurance without convincing these key figures beforehand. The initiative takers and these important local authorities must convince the population of the importance they attach to this new project.

In many developing countries, the concepts of ‘insurance’ and ‘prevention’ are barely known. Therefore, spelling out the importance of preventive measures is a major element in generating awareness.

The initiative takers must assess whether there is enough interest among potential members to warrant the creation of a project to improve access to health care services. Assuming that the parties involved do decide to set up a micro-insurance
institution, the process of informing and raising awareness among the target group will be a permanent concern.

4.3 Feasibility study

By means of a feasibility study, the initiative takers gather the information they need to work out a number of scenarios. How much do people currently pay for their health care services? What are the most common ailments? Which services or activities can be reimbursed if they pay a contribution of X amount? Or, vice-versa: if the micro-insurance system is set up to reimburse Y or Z, how much will this cost its members? When should the initiative takers collect the contributions? The scenarios are explained to a broad group of the population and they ultimately make a choice.

There is a certain amount of information required, including:

- level of membership fees,
- care or risks covered by the micro-insurance,
- level of reimbursement for care/provisions,
- choice of care providers,
- organisational model on which the micro-insurance is based,
- activities of the micro-insurance institution.

4.4 Training

Training managers for these micro-insurance institutions is a very important part of the process and a lot of training is needed before the micro-insurance initiative can start. Since training is an ongoing concern, a number of supporting authorities have developed training modules.
PROMUSAF (WSM-CM)

An NGO by the name of Wereldsolidariteit (WSM), and the Confederation of Christian Mutual Health Insurance Funds of Belgium (LCM), were present at the inauguration of the ‘Support Programme for Mutual Insurance in West Africa’ (PROMUSAF). The programme started in 1998 in Benin, Burkina Faso and Senegal. Mali joined in 2002. The DGOS (the Belgian Directorate-General for Development Cooperation) contributes to the programme.

At this point in time, PROMUSAF is supporting 97 micro-insurance institutions:

<table>
<thead>
<tr>
<th>Country</th>
<th>micro ins.</th>
<th>members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senegal</td>
<td>38</td>
<td>10,500</td>
</tr>
<tr>
<td>Mali</td>
<td>22</td>
<td>13,000</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>25</td>
<td>2,500</td>
</tr>
<tr>
<td>Benin</td>
<td>12</td>
<td>1,500</td>
</tr>
<tr>
<td>Total</td>
<td>97</td>
<td>27,500</td>
</tr>
</tbody>
</table>

PROMUSAF operates in four areas:

1. Supporting the development of micro-insurance initiatives;
2. Coordinating micro-insurance institution networks and other support organisations;
3. Stimulating wage-earning activities for local people to help them afford their micro-insurance contributions;
4. Political action to improve access to health care services.

A few examples of the type of action undertaken:

1. Information sessions, feasibility studies, awareness-raising, health education;
2. Establishing ties of friendship between mutual organisations from the North and South, helping to draft a law for mutual health insurance services and micro-insurance institutions;
3. Granting micro-loans in trades including (poultry) farming, market trading and vegetable growing so the people can pay their premium.

The STEP training package, for example, covers the following subjects:

- theory and formation of a micro-insurance institution,
- feasibility study,
- administrative and financial management,
- monitoring and evaluation.

4.5 Formation of a micro-insurance institution

The initiative takers usually engineer a formal occasion on which to found the micro-insurance institution. The first General Meeting approves the byelaws of the association, appoints the directors and processes the first members’ subscriptions. At this
meeting, the institution collects its first subscription fees and premiums. As of then, the first members are theoretically entitled to reclaim their medical expenses from the micro-insurance institution.

4.6 Monitoring and evaluation

It is important that the parties involved keep a very close eye on this newly formed micro-insurance institution. The initial months are a real test of people’s belief in the system. Will they pay their contributions regularly? Will the health care workers abide by the rules? In most cases, the institution won’t pay out any benefits in the first few months. Members have to keep paying their contributions for an agreed period to make sure the funds reach an adequate critical mass. They also have to show that they are willing to continue with their financial contributions to the micro-insurance fund. During this opening period, it is crucial that there is sufficient contact between the micro-insurance institution and the population it serves. This is the only way the initiators will be able to assess the population’s thoughts on the new organisation. Any misunderstandings must be ironed out immediately.
THE ADVANTAGES OF MICRO-INSURANCE INSTITUTIONS IN HEALTH CARE

5.1 Better access to health care services

High and low-income families, sick and healthy people all contribute to the micro-insurance institution. Although it is highly likely that sick and elderly subscribers will make more use of the health care services than the young and healthy, their membership fees will not be any higher. This is redistribution based on solidarity. In this sense, the micro-insurance institution is an instrument of social justice. The system works best for the most vulnerable people who would otherwise have no real access to the health care system.

5.2 Better organisation and quality of the health care provisions

Micro-insurance institutions can have a very positive effect on the quality of health care provision and how the related services are organised. To start with, the very existence of a micro-insurance institution can give the managers of these services a better idea of the real needs and requirements of the local population. It can help them adapt their investment policies and services to suit demand. A micro-insurance institution can also ensure a more stable income for the health centres. This can filter through in the form of improved care and more efficient services. In this respect, the presence of such an institution can lead indirectly to improved health care services. With these extra funds, for example, the health services institution can buy more medi-
The Tokombéré project

In 1997, in Tokombéré in the extreme north of Cameroon, a development project was set up in several areas, namely health care, opportunities for young people and women, and literacy. Tokombéré has a well-run hospital with 150 beds, and it distributes the medical expenses and risks in two ways.

Firstly, patients pay a fixed fee to cover the cost of the consultation, medical care, prescribed medicines and hospitalisation expenses for fifteen days. On top of that, they pay fixed rates for things such as blood transfusions, surgery, and treatments for tuberculosis or hepatitis. To cover chronic diseases, the patients pay a fixed monthly sum. Patients living in the district pay less than those living further afield. Primary health care provided by health workers in a local dispensary costs less than a consultation in a central clinic.

Secondly, Tokombéré operates a pre-payment system for children under the age of 5, school pupils and pregnant women. These groups can buy a health card giving them free access to medical care. The children’s health card gives entitlement to free consultations and vaccinations. When a child reaches the age of five, his parents buy a new health card which gives entitlement to reduced-price consultations, booster vaccinations and health education. Pregnant women with a health card have access to free advice, medicines and vaccinations during pregnancy.

These systems have improved access to health care in the region greatly. More people are attending hospital, sick people are being treated earlier, vaccinations are more widespread, the district has fewer epidemics, the population has a greater say in the district health policy, and midwives are attending more and more childbirths.
managers and personnel usually have a great deal of contact with the local population, the members, and the users of the health care services. This means that the micro-insurance institution actually represents a large section of the population whose interests it can represent before the decision-making authorities in the health care sector. In this way, it can try to affect issues such as which products and services are provided, who should have access to them, who should pay what for the privilege, and how much should be spent on prevention and information. In some countries, micro-insurance institutions only have an opportunity to influence policy decisions on an occasional basis. In others, however, there are structures for consultations between the micro-insurance institutions, the health care providers, and the government.

5.4 Promoting the general welfare and social integration of members

Micro-insurance institutions can improve the overall social status of their members. Issues such as quality of the services. In some cases, the micro-insurance institution can negotiate with the suppliers of pharmaceutical products to obtain the best price on frequently used medicines. Finally, micro-insurance institutions have an interest in health education and preventive care. As insurance organisations, they all have a vested interest in ensuring that their affiliated members remain in good health and use the medical services as little as possible. Health care services often find it difficult to keep the population informed of health issues and preventive measures. However, they can work with the micro-insurance institutions to extend their reach.

5.3 Contribution to furthering democratic management in health care services

Micro-insurance institutions also bring a degree of democracy to the health care sector. Members of the institution can air their opinions and concerns at the general meeting and other gatherings. The institutions in rural Guinea was not participating on a large-scale had nothing to do with a lack of understanding or acceptance of the underlying values of the mutual insurance principle, but it did have to do with the inferior quality of the care offered by the public health care services and the affordability of the one-off fee for large or low-income households.

PRIMA (Guinée-Conakry)

In 1996, the Belgian Institute of Tropical Medicine started the PRIMA research project in Guinée-Conakry. The survey revealed that any development of micro-insurance institutions would have to take place within a wider view of health care issues. This implied interventions from several angles at the same time. The fact that the group targeted by the micro-insurance institutions in rural Guinea was not participating on a large-scale had nothing to do with a lack of understanding or acceptance of the underlying values of the mutual insurance principle, but it did have to do with the inferior quality of the care offered by the public health care services and the affordability of the one-off fee for large or low-income households.

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family planning, inoculation, sex education and health education are much easier to deal with in the context of a micro-insurance institution. Prevention, information and awareness-raising are part and parcel of the everyday activities of a micro-insurance institution. If it encourages its members to participate in the way it is run, it will also stimulate a sense of initiative and responsibility and encourage individuals to take the future into their own hands.
6 DANGERS AND POTENTIAL SOLUTIONS

Several factors can constitute a threat to a micro-insurance institution’s survival. These threats are common to all forms of insurance. However, the micro-insurance institution will need to take very different evasive action than would its counterpart in the private insurance sector.

These risks, and how to avoid them, is discussed below. Please note that these solutions are theoretical. Research has shown that it is not easy to bring a small micro-insurance institution into being. Some of the measures we propose here make the insurance a little less attractive to members. Micro-insurance attempts to strike a balance between attracting members in sufficient numbers and protecting the system against the risks mentioned below.

6.1 Negative selection

We use the term negative selection to describe a situation in which people with a high risk of becoming sick subscribe in massive numbers and healthier people do not join or opt out of the system after only a brief membership. This situation undermines the financial viability of the micro-insurance institution because the health costs per member are excessively high.

The aim then is to attract healthy people to the system. This can be done by subscribing a whole family, or persuading an entire group (e.g. a women’s group) to join. A waiting period of three to six months can be helpful to prevent people from joining up when they feel ill. Once this initial period has expired, the insured can have his or her medical expenses reimbursed.

In practice, the people in charge of running micro-insurance institutions often say that it is far from easy to refuse someone’s costs if they become sick during this waiting period. This may discourage them, or prevent people they know from joining or even staying in the micro-insurance system.

6.2 Over-consumption (‘the moral risk’)

There is a risk that members and their dependants will try to get the most for their money and use the services more than they need to, which also undermines the financial viability of the micro-insurance institution. Such institutions should therefore raise their members’ awareness of the dangers of over-consumption. To reduce the risk of over-consumption, users are asked to pay a part of the health care costs themselves. This small fee, a non-refundable contribution to the medical expenses, creates a sort of threshold. Research in West Africa reveals that there is very little over-consumption reported in that region. Although the risk is well known to our western insurance systems and our experts warn against it, it must be said that there is at present little evidence of it in West African society. This is a good example of why it is not enough to simply transplant the risks and success factors particular to our system to other continents without taking the local context into account.
6.3 Over-prescription

Closely related to the problem of over-consumption we have the problem of over-prescription. Members know that the micro-insurance institution will refund their health costs, so they are slow to complain if the health services institution prescribes expensive but unnecessary treatments. In order to prevent over-prescription, the micro-insurance institution can enter into agreements with the health services institution. These agreements stipulate that the health care providers prescribe generic medicines only and stick to standard treatment schedules. In practice, it seems that in the early days quite a few micro-insurance institutions have difficulty monitoring these agreements. Since members pay a part of the expenses themselves, they tend to shy away from expensive courses of treatment and this helps institutions keep a close eye on prescription behaviour.

6.4 Deception and misuse

The terms deception and misuse describe the situation in which a person claims a refund of expenses without paying their membership fee or premiums. Members may find themselves forced by their family or neighbours into passing someone off as a family member. Likewise, the head of a family may pay membership fees for several family members, but claim a refund for the medical expenses incurred by a different, non-covered family member. This is a widespread problem. Awareness-raising can help, but it is not enough. The insurance system must be able to check whether the person passing himself off as a member or dependant really is who he says he is. This is not a problem in a small community since everybody knows each other. In the case of larger communities or micro-insurance institutions, it can prove a tougher problem to solve.

The micro-insurance institution can choose to check a person’s identity when they ask for health care. For example, the institution gives the patients a letter to take with them to the health services institution, or it can run an identity check before refunding the expenses. This is easier said than done. One simple solution would be to use passport photos, but in very poor countries, like those in Sub-Saharan Africa, or in rural areas, passport photos are neither practical nor financially realistic. They serve only to increase the registration fees and so discourage people from joining. Some micro-insurance institutions try to dissuade abusers of the system by publicising and imposing sanctions.

6.5 Emergencies

A micro-insurance institution can go under if suddenly faced with a mass of claims as the result of an epidemic, natural disaster or violent conflict. Micro-insurance institutions seldom have a reserve that can cope with a situation of this type. If a micro-insurance organisation wants to put aside reserves to cover this risk, it will have to make the contributions a little higher and this will scare off potential members. Having said that, the government and external donors sometimes provide funds if a disaster occurs. In a case like this, there is no need for high contributions. In order to cover this type of risk, the micro-insurance institution might set up or appeal to a guarantee fund or reinsurance institution (see further). This option is seldom available, however, to small-scale initiatives. If it has none
of the options above available, the micro-insurance institution may have no other option but to put a ceiling on the benefits it pays out. To avoid excessive refund payments, a micro-insurance institution may decide not to refund the medical expenses for certain chronic disorders. This runs contrary to the idea that these institutions do not assess their members individually on the basis of health risk. Some systems use special government or donor programmes, for example, to finance treatment for patients with HIV/AIDS.

6.6 The problems facing new micro-insurance institutions active in health care

In the early days, micro-insurance institutions often experience the same problems. When these institutions are in their infancy, people tend to wait and see if they really work before joining. The problem is that a micro-insurance system needs a broad base if it is to operate properly. The broader the group of risk-sharing individuals, the lower the premiums and the more comprehensive the insurance coverage. If people join in insufficient numbers to start with, a young institution will never become an attractive proposition. What we often see as well is that a lot of members want to keep the premiums small in the beginning, even though they can afford a little more. They want to see if the system works before agreeing to a higher contribution. Yet again, this has the effect of making the capabilities of the micro-insurance institution appear quite unattractive from the outset. So there we have it – the most serious problems a micro-insurance institution is likely to face. These
problems are real and every institution has to take steps to avoid the pitfalls. However, many of these measures are not really that popular. Let’s take, for example, the requirement that all members of the family be insured at the same time, having to have your identity and insurance papers checked by the person in charge of the micro-insurance system, and not being covered for certain treatments.

In addition, there is the complication that many health care workers are not adequately informed of the role and activities of these micro-insurance institutions. They don’t treat the insured patients in the way they are expected to: give them a cold and unfriendly reception, refuse to accept their membership cards, and fail to honour their contract with the micro-insurance institution. This can cause members to become disillusioned. They had expected something altogether different from the micro-insurance institution: they were promised that things would be better.

All these factors have an effect on the regularity with which people are prepared to pay their contributions, and beyond that they colour the views of people who may be on the verge of joining. Word of mouth is the best possible advertisement for the new micro-insurance institution. Obviously, information and awareness-raising are important ways of preventing initial members from becoming discouraged and making them believe in the institution. Yet these problems cannot be avoided in the early stages and can weaken any young micro-insurance institution.
It is important that the micro-insurance institutions find the right balance between the individual contributions and the refunds paid out for accidents and illnesses. The link between the contributions and refunds is highly dependent on the probability of a risk occurring. In turn, this risk is determined by the individual risk, i.e. the probability that a member will become sick or fall victim to an accident.

If the sum of the expenses refunded is greater than the sum of the individual contributions, that balance will have been lost and the viability of the insurance institution will come under serious threat. If the institution has managed to build up a reserve, or if an external partner is prepared to make up the shortfall, the institution will be able to bridge this loss-making period in the hope that the risks will diminish in the future. If not, the institution will be forced to re-establish the balance either by increasing the contributions or reducing the refunds.

Research reveal that most micro-insurance institutions run at a loss in their first few years of existence due to the fact that they keep the premiums low to attract and retain members.

A micro-insurance institution will be able to enhance its viability if it can share the risk with other micro-insurance institutions by setting up a federation or reinsuring its activities. Under the normal system of reinsurance, the micro-insurance institution pays a contribution and the reinsurance institution bears
the costs incurred in the wake of pre-defined extreme risks, such as epidemics, natural disasters or solvency problems. If a reinsurance institution can reinsure several micro-insurance institutions from different regions of the same country or continent, this will help it spread the risk geographically.

There are a number of advantages to be gained from reinsuring a micro-insurance institution.

First of all, the process of reinsuring will enhance the financial viability of the micro-insurance institution: it will be able to avoid catastrophic losses and may even build up a reserve. It can invest this reserve in health care provisions or better services and insurance packages.

Second, it lends greater credibility to the micro-insurance institution since the institution is always capable of living up to its promises. This can be a factor that convinces more people to join.

The third advantage is that the micro-insurance institution will be forced to provide the re-insurer with information on its membership numbers, contributions and refunds. This will ensure that it keeps proper records of its accounts.

Fourth, a reinsurance system can provide a link with centralised funds (state, international donors, etc.) as well as local funds. Instead of subsidising local initiatives, a government or NGO can then pay the reinsurance premium itself and in this way promote the micro-insurer’s financial independence.

In the case of a disaster, the international community would also be able to use the network of micro-insurance institutions and reinsurance systems to make sure that aid arrives in the right place at the right time. Following this line of reasoning, at any given time the micro-insurance institution can
provide the international community with trained workers who understand the needs of the local population and are familiar with financial transactions.

In theory, reinsurance opens up a wealth of possibilities for micro-insurance institutions in the health care systems of developing countries. In practice, however, it is not that simple. Micro-insurance institutions usually operate on a small scale and the initiative takers are usually volunteers whose function does not involve analysing the minutiae of the accounts. They are often local initiatives working in isolation, with no ties or contacts at the regional or national level. It is only very recently that we have begun to see local micro-insurance institutions attempting to join networks and set up reinsurance systems.
8 IMPORTANT POINTS IN THE DEVELOPMENT OF MICRO-INSURANCE INSTITUTIONS

8.1 The importance of context

If an organisation sets out to help a population develop micro-insurance initiatives for itself, it will have to operate in the context of the social and political situation in that country or region and turn its attention to several questions: What type of health care does the government provide? What types of social security are already in place? Is the health care policy centralised or de-centralised? What is the relationship between the government and the private sector? Is the government making moves towards the private sector to create better conditions? Or does it attempt to foil private sector initiatives? Does the country’s medical sector carry any real political weight? Do the doctors and nurses care about the interests of the patients? How is civil society organised? Does civil society organisations stand up for the common goods or is it a case of everyone for himself?

8.2 The ‘bottom-up’ approach

Although the government, the private sector and the external support organisations are major players in the field, they do not have the ability to force the population to set up their own micro-insurance institutions. What is needed here is the bottom-up approach. This implies that while the players do have the power to encourage the population and pave the way for the initiative, the final push must come from the people and the local organisations themselves. It is only when people see the usefulness of a system of this type that they can put their energies into it and give the initiative a chance of success.

Louvain Développement

Louvain Développement is a consortium of six Belgian NGOs. Louvain Développement supports initiatives in Bolivia, Peru, Madagascar, the Congo, Togo, Benin and Brazil. It is the purpose of this consortium to bring about sustainable improvements in the living conditions and health of the groups targeted by its projects. On top of this, Louvain Développement aims to improve the political, social and economic power of these groups.

In Togo, this NGO supports four mutual health insurance institutions. These micro-insurance organisations are active in 110 villages and are closely allied to the local farmers’ organisations and their savings and loans structures.
### FOS - Mútua del Campo

FOS is the NGO associated with the socialist movement in Flanders. NVSM, the National Union of Socialist Mutual Health Insurance Funds, has been working with FOS since 1990 in support of Mútua del Campo in Nicaragua. Since 1990, after the demise of the strong public health care sector, the FOS has set up four peoples’ clinics. Up to this point, there had been no talk of a micro-insurance system. Between 1995 and 2000, FOS contributed funds to the foundation and development of a mutual organisation for businesses in the central highlands of Nicaragua. In this project, it cooperated with a well-run national farmers’ union and an organised body of coffee plantation workers. The quality of the health care services has improved in the region and between 1995 and 2000, the number of members grew from 450 to 1,500 members (9,000 beneficiaries). Other enterprises and private individuals were also invited to use the medical services, subject to a fee. Access to these health care services improved, but not for the poorest community members who found the contributions excessively high.

In 2000, the price of coffee on world markets collapsed. This culminated in widespread unemployment, a mass exodus from the coffee plantations, a halving of the organisation’s members, overcapacity, and the closure of two medical units.

After a thorough evaluation of its activities, the FOS, the NVSM and the local partner organisations decided to reorganise the Mútua internally, to promote it in other departments of the country, and to run the medical units more strictly in line with the principles of self-financing. It is thus clear that dependence on a single economic sector is a real risk to an institution’s sustainability.

### 8.3 Open-ended initiatives

As we have seen from above, no group of people can start off with a ready-made micro-insurance system.

It is not simply because a system works well in one situation that it will be as effective in another. The people on the ground have to set up a system that meets their needs and fits in perfectly with their environment. Having done that, they need to fine-tune this system and adjust it to accommodate any change.

### 8.4 The need for networking and information exchange

We have seen that there are numerous organisations willing to support emerging micro-insurance institutions. There are national and international support organisations, non-governmental, governmental...
La Concertation

La Concertation is a network of partners who encourage the development of mutual health insurance institutions in West and Central Africa. This network exchanges information, expertise and experience dealing with micro-insurance systems in health care on the African continent. It was created following a meeting in Abidjan in June 1998.

Since 1999, La Concertation has set up a variety of activities, including:
- running an Internet site (www.concertation.org). Among other things, this site provides recent information on micro-insurance, a diary of activities, a discussion forum, and contacts in several countries. Members receive a regular newsflash.
- distributing the information booklet ‘Courrier de la Concertation’. This booklet supplements the site and provides information to people who do not have access to the Internet.
- tracking national and international trends in the micro-insurance sector.
- organising a biennial forum of workshops. The various countries organise meetings for the partners involved.

La Concertation carries out its activities in eleven countries: Senegal, Benin, Burkina Faso, Guinea, Togo, Chad, Cameroon, Mauritania, the Ivory Coast, Mali and Nigeria. La Concertation receives technical and financial support from several organisations such as the International Labour Organisation (ILO/STEP), the American development organisation USAID/PHRplus, the German Development Cooperation organisation GTZ (health insurance), the International Association of Mutuals (AIM), the Belgian Confederation of Christian Mutual Health Insurance Funds, the Belgian NGO Wereldsolidariteit (WSM) the French Support Network for Health Mutuals (RAMUS), and the Belgian National Union of Socialist Mutual Health Insurance Fund.
Conclusions

The best way to look at micro-insurance institutions is as a form of social protection in the health care sector. In the last ten years, initiatives of this type have been promoted in a great many developing countries. As yet, there has been no great breakthrough, but in many countries tens of fairly small-scale systems are beginning to emerge. These initiatives are starting to redefine the tasks of the players in the health care sector. The task of governments is a new but very important one: it is up to governments to describe the general framework within which social protection is to be extended to all levels of the population. In so doing, they can choose any of several mechanisms designed to redistribute resources and engender solidarity among various groups of the population. This new division of tasks encourages health care workers to provide quality services and listen to the wishes and complaints of local patients. Lastly, these micro-insurance institutions give the population an opportunity to show their solidarity and voice their opinions before governments and health care service providers.
**List of important players**

**Strategies and Tools against Social Exclusion and Poverty (STEP) / International Labour Organisation (ILO)**
4, Route des Morillons
CH-1211 Geneva 22
Switzerland
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step@ilo.org
www.ilo.org

**Cera Holding – Belgian Raiffeisen Foundation (BRS)**
Philipssite 5 b10
3001 Leuven
Belgium
Phone: 0032 70 69 52 42
Fax: 0032 70 69 52 42
www.ceraholding.be
www.brs-vzw.be
www.cerafoundation.be

**FOS – Socialistische Solidariteit VZW**
Grasmarkt 105 b46
1000 Brussels
Belgium
Phone: 0032 2 552 03 00
Fax: 0032 2 552 02 96
www.fos-socso.be

**National Union of Socialist Mutual Health Insurance Funds**
Sint-Janssstraat 32-38
1000 Brussels
Phone: 0032 2 515 02 11
Fax: 0032 2 515 02 07
www.mutsoc.be

**Wereldsolidariteit (WSM)**
Haachtsesteenweg 579
1031 Brussels
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Phone: 0032 2 246 36 85
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www.wereldsolidariteit.be

**Prince Leopold Institute for Tropical Medicine**
Nationalestraat 155
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Directorate General for Development Cooperation (DGOS)
Ministry of Foreign Affairs, Foreign Trade and Development Cooperation
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Phone: 0032 2 501 81 11
www.dgos.be

Belgian Technical Cooperation (BTC)
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Confederation of Christian Mutual Health Insurance Funds (LCM)
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Fax: 0049 61 96 79 115
www.gtz.be

The Partners for Health Reform plus (PHRplus) Project
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BIT/STEP-Afrique (2003), Manuel sur le concept, la mise en place et le fonctionnement de micro-assurance santé, Dakar.

Defourny, J. (2003), Les mutuelles de santé, une voie pleine d’avenir en Afrique, Centre d’Economie Sociale, Université de Liège.


Providing health care in developing countries is no easy matter. The products and services are limited and expensive, the quality is bad, the personnel are under-motivated and there is an insufficient supply of affordable medicines. On top of that, patients are dropping out of the system. To put it briefly, the overwhelming majority of people in developing countries are suffering from the lack of a social protection net.

Micro-insurance institutions are being set up in Africa, Asia and Latin America in response to this ailing health care situation. Some of these institutions are very large, yet others count their members in the hundreds. These organisations knit together the local population and make sure that inhabitants cover themselves against the risk of illness. Micro-insurance institutions do more than simply pool the financial resources of local people; they negotiate with medical personnel to improve the quality of the services provided and give their members advice and information.

In this brochure, the authors look at how micro-insurance institutions can improve access to health care, as well as the other advantages they bring to the health care sector. They go on to describe the problems encountered when people start up a micro-insurance institution of their own. Finally, the authors pay particular attention to the financial viability of young micro-insurance institutions and the way in which development organisations can provide support for these new, often fragile local institutions.

The authors illustrate their findings with numerous examples from very different countries.

This brochure offers clear insights and food for thought to the initiative takers and managers of micro-insurance institutions, and to anyone else with an interest in health care in developing countries.

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