



Extrait du CIDR

<http://cidr.org/The-Forestry-Guinean-Mutual-Health.html>

The Forestry Guinean Mutual Health Organizations' Union (UMSGF) - Guinea - CGAP Working Group on Microinsurance - Case Study n° 17

- English contents -



Date de mise en ligne : Tuesday 11 July 2006

Description :

The topic of the conference where this document was presented was "making insurance accessible to the poor - Better practices and lessons learned". It describes CIDR's experience promoting a regional network of mutual health insurance organizations in «Guinée Forestière».

Copyright © CIDR - All rights reserved

The Forestry Guinean Mutual Health Organizations' Union (UMSGF) - Guinea - CGAP Working Group on Microinsurance - Case Study n° 17

Authors: Bruno Gautier, Allan Boutbien, Bruno Galland.

Title : The Forestry Guinean Mutual Health Organizations' Union (UMSGF)- CGAP Working Group on Microinsurance - Case Study n° 17

Subject: This document was presented in the context of the international year of microcredit during a conference on microinsurance organized by the CGAP ([Consultative Group to Assist the Poor](#)) in partnership with the [Fondation Munich Re](#) in October 2005. The topic of the conference was "making insurance accessible to the poor - Better practices and lessons learned". It describes CIDR's experience promoting a regional network of mutual health insurance organizations in «Guinée Forestière».

Date of publication: October 2005.

Financing: CGAP/BIT

The Union des Mutuelles de Santé de Guinée Forestière (UMSGF) is an association of mutual health organizations (MHOs). It was established as part of a health insurance program initiated in 1999 by the International Centre for Development and Research (CIDR). Overall, the insurance sector in Guinea is underdeveloped and neither the target populations nor health care providers are particularly familiar with health insurance.

Forestry Guinea is a region with strong agricultural potential, inhabited by a variety of ethnic groups in villages that are relatively isolated from the main urban areas. The role health microinsurance could play was recognized once preliminary studies determined that the target population was facing serious financial difficulties in accessing health care services despite the fact that public facilities charged relatively low fees. The inability to access health care was connected to the target population's irregular cash flow, including lengthy lean periods with more expenses than income.

In Guinea, CIDR chose to organize the management and governance functions of microinsurance according to the principles of mutualism because of the local social dynamics, such as cohesive communities with multiple self-help organizations. Additionally, there was an absence of formal social or professional organizations that could have undertaken the tasks of management and product distribution.

The current program was divided into three phases: a pilot phase to test microinsurance products and the mutual model (1999-2002); a consolidation phase in which a regional network of mutual health organizations was created (2002-2005); and an institutionalisation phase that will facilitate the gradual withdrawal of CIDR's support (2005-2007).

Health credit managed by self-help groups and health insurance with cash reimbursements to members were tested during the pilot phase. However, these were quickly replaced with a more attractive insurance arrangement with direct third-party payments to contracted public health facilities.

From its inception, the MHOs' network has experienced steady internal and external growth.¹ By 2005, the UMSGF has brought together 21 rural and 7 urban MHOs comprising of a total membership of 2,656 families and 14,071

individuals, or roughly 100 families per scheme. This is equivalent to about 10 percent of the target group in those areas.

To meet the needs and financial capabilities of their target populations, the MHOs designed low-cost products (Euros1.3 premium per person per year in 2005) that offered benefits for hospitalization and surgical procedures at public health facilities. This situation was gradually modified to take into account the diversification of available health care delivery services, as not-for-profit providers increased. The benefits were also modified to meet the demands of the members, such as the addition of outpatient care.

Within 5 years, the adopted insurance management strategy has enabled mutual health organizations to build sufficient equity (Euros19,500 over 5 years from an annual volume of collected premiums of Euros12,000 for 2004/05), so they could embark on product diversification. The MHOs benefit from a guarantee system that provides them with access to an intervention fund should their reserves fall below a safety threshold.

The project has a specialized Technical Unit to organize risk monitoring and management functions that go beyond MHOs' primary capacities. In the near future, the technical staff (risk manager and medical doctor) will be employed by the UMSGF. The Union's major challenge is for all of the network's organizations to cover their expenses in the years to come. MHOs will have to allocate 17.5 percent of their collected premiums to pay for the Technical Unit's services and to cover the Union's running costs.

Increasing the membership of the MHOs and the size of the network is a challenge that must be overcome to ensure financial independence. The breakeven point to establish financial independence is predicted to be around 60,000 members. This membership level could be reached if the health care quality and the target group's purchasing power does not erode.

In the absence of specific legislation regulating mutual organizations, a not-for-profit organization status was adopted as a temporary measure. The UMSGF is involved in discussions taking place at the national level to draft a bill adapted to its particular status within Guinea.

Lessons: Technical Aspects

Product design

Although according to mutual principles, members choose their benefits, the operator's initial power of induction is strong. It must have a sound knowledge of the target 1 External growth is the establishment of new MHOs; internal growth is an increase of members within an existing MHO. groups' purchasing power and preferences to design products that are both appealing to, and affordable for, a significant part of the target population.

Positioning the product's selling price above its actual cost price turned out to be a strategy suitable to the context in which the MHOs' were established. It enabled them to build equity without imposing lengthy waiting periods on their members. In the end, MHOs will probably need to design multiple products to maximize their membership.

Marketing and communication strategy

Specific sensitisation, information and communication activities must be carried out over a long period of time by specialized staff. Elected officials' capacity and availability in handling these activities by themselves should not be over-estimated. MHOs are not in a position to fund this initial investment out of their own resources.

Member subscription through mutual groups has proved useful since it eases premium collection, improves information flows and, when necessary, is a means of organizing members' representation within the governance bodies.

Health risk management and control

Health providers' behaviour has a major effect on the viability of health insurance products. Specific monitoring and control measures have to be set up. Calling in a medical consultant and hiring liaison officers to assist the insured within health facilities are important means of preventing potential conflicts or disputes between scheme members and health staff, and between MHOs and health providers.

Customer lessons

For its target market, the program chose low-income unorganized populations with little schooling, living primarily in rural areas. The observed level of contributions makes it impossible for the network to reach full financial independence if it only serves this group. It would be preferable for the Technical Unit to generate additional income by providing services to other mutual health systems rather than diversifying target group within the UMSGF, which would risk diverting it from its initial mission.

Lessons: Institutional Aspects

Reaching MHOs' maximum capacity for autonomous management should be an important preoccupation for the technical support operator. The latter must not assign MHOs' elected officials with day-to-day managerial functions that they cannot perform in the long run. Offering MHO managers a cash incentive of up to 5 percent of collected premiums appears to be an efficient measure to maintain them in their function. The MHOs' limited capacities to manage health microinsurance in a professional way must be taken into account.

Therefore, it is advisable to place MHOs in a regional network to ensure their sustainability. During the structuring phase, the sharing of responsibilities, functions and tasks between primary MHOs and the central level must be clearly defined in consultation with the elected officials. Elected officials and scheme managers must be given as much autonomy as possible to administer and run their organizations.