Learning Journey

Centre de recherche médecine, sciences, santé et société (CERMES)

Feasibility of resource mobilization among migrant communities for developing health microinsurance in the country of origin

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Project Basics

About the project

Centre de Recherche Médecine, Sciences, Santé et Société (CERMES) is a social and human sciences research unit specialized in the area of health. It brings together 40 researchers from CNRS, INSERM, universities, and doctoral students from diverse disciplines (sociology, economics, public health and history). CERMES is associated with the École des Hautes Études en Sciences Sociales (EHESS) at the universities of Paris V and XI.

The purpose of this project is to evaluate, in three countries (Kayes Region of Mali, Matam Region of Senegal and at Ngazidjain in the Comoros), the feasibility of migrant communities contributing full or partial payment for health microinsurance for their families at home. The first phase of the project consists of case studies of similar experiences, followed by a feasibility analysis to estimate money transfer amounts, determine the willingness of the migrant communities to transfer funds for microinsurance and evaluate the organizational capacity in both the country of migration and of origin. Depending on the outcomes of these evaluations, a number of trial projects will be implemented: in Mali, the trial could enlist the collaboration of the Union Technique de la Mutualité Malienne (UTM), a mutual health insurance operator with a branch in Kayes. At Ngazidja, the mutual health organization network, established by the Fédération nationale des mutuelles de santé des Comores (FENAMUSAC), with the support of the International Development Research Centre (IDRC), could serve as the health insurance operator. Lastly, in Matam Region, there is no functioning health insurance operator and the trial will need to set up a local operator.

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<th>Project Summary</th>
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<td><strong>Project name:</strong> Resource mobilization among migrant communities for developing health microinsurance in the country of origin</td>
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<td><strong>Launch date:</strong> January 2010</td>
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<td><strong>Duration:</strong> Three years</td>
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<td><strong>Country:</strong> Mali, Senegal, the Comoros</td>
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<td><strong>Product:</strong> Health product – coverage of primary and secondary care</td>
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Project Updates

What is happening?

At 31st May 2012

Case studies carried out

In 2010, five case studies were carried out in order to gain an understanding of existing experiences of migrant contributions to health insurance schemes through money transfers.

1. Sécurité Sociale Villageoise (SSV), the Comoros
   - The model: Implemented by CIDR (Centre International de Développement et de Recherche), a French NGO, this village-based social security scheme (SSV) makes mandatory health coverage possible at the village level with the financial support of the migrant community. It is the village's decision whether or not to set up an SSV. The migrant community’s contribution to the system is indirect: a village association in France composed of migrants remits funds to village authorities to subsidize development activities decided by the village. In villages opting for the creation of an SSV, part of the funds sent by migrants is used to fund the operational costs of the SSV.
   - Outcomes: The first SSV schemes began activities in 2002 and at present six villages are covered. However, the model has its limitations: problems with governance, administrative difficulties related to village-level enrolment (registration of beneficiaries and premium collection, in particular) and lack of transparency in the use of migrant funds despite the importance placed on this by migrants. This model is no longer used by CIDR to promote the development of a mutual insurance system in the Comoros.

2. La Mutuelle des Maliens de l’Extérieur (MME), Mali
   - The model: MME is a mutual association under French law, created in 1993. Its members are migrants who pay fees to provide health coverage for their families at home. Initially, MME limited health coverage to residents of villages where the health care available was thought sufficiently good quality for the purposes of the trial. However, it quickly became clear that population mobility trends in Mali made national coverage necessary. This was made possible by the creation of UTM (Union Technique de la Mutualité) and the development of a standard product (Voluntary Mutual Health Insurance or Assurance Mutuelle Volontaire (AMV)) offering primary and secondary health care throughout the country at UTM-affiliated health facilities. Premium management and enrolment are dealt with externally by the Union des Mutuelles Cogérées (UMC), of which MME is a member. Claims are handled by UTM.
   - Outcomes: Although still in operation, MME has only recruited a few hundred members. This small number is in part due to a lack of resources and communication strategy in France, since the functioning of mutual associations in France is based on volunteer work by its members.
3. **Mutuelle santé/transport, Mali**
   - The model: This health care and transportation mutual organization under Malian law was created in January 2011. It was initiated by the Malian diaspora in France originating from Kayes Region on the basis of a feasibility study involving 20 villages. It offers health insurance through public health centres and hospitals to all interested families (including those not supported by migrants in France). For families supported by migrants in France, the premiums can be paid by the migrant. PromuTs, an association under French law, is in charge of creating awareness and collecting premiums.
   - Outcomes: The mutual organization began activities in January 2011 but is struggling to draw members (several hundred to date) and to finance the personnel needed to function.

4. **Assistance des Résidents Immigrés pour leur Famille en Afrique (ARIFA), Senegal**
   - The model: This association under French law came into existence in the 90s, initiated by a Franco-Senegalese employee of an insurance company. In partnership with SONAM (Société nationale d’Assurances Mutuelles), a Senegalese mutual insurance provider, ARIFA offered Senegalese migrants the possibility of purchasing a health insurance product for their family in Senegal. In France, ARIFA collected funds from migrants and kept the list of beneficiaries; in Senegal, SONAM was in charge of claims processing and carried the risk. Precise membership figures could not be obtained, but, according to SONAM hundreds were enrolled.
   - Outcomes: ARIFA ended its contract with SONAM (for reasons the case study was unable to ascertain) and sought the support of local partners to manage health care providers. Under the new structure, it was not possible to sufficiently monitor claim rates and local agreements between managers and providers, resulting in an excessive increase in costs and the demise of the initiative.

5. **The Appui à la Diaspora Africaine aux Mutuelles Sociales (ADAMS) programme, West Africa**
   - The model: With the ADAMS project, EcoLabs Programme Association (EPA), aims to facilitate migrants’ contribution to health insurance for their families at home by acting as the intermediary between the migrant, the beneficiary and the mutual organization chosen. The programme uses an on-line payment platform connected to the mutual, which allows migrants to make payments on behalf of beneficiaries. This principle can be applied to all countries whose mutual insurance organizations are integrated into the system. In principle, a sponsor can pay for any person, not only family members. Contribution payments are individualized, so it is not necessary for sponsors to be grouped in some kind of association. The programme covers the fees to transfer the funds from the sponsor’s bank account to the mutual organization’s account. Once the payment has been received, the mutual organization issues an insurance card to the beneficiary who can exercise his or her rights within the policy limits.
Outcomes: The programme’s success rests on Ecolabs’ ability to establish links with a large number of existing mutual organizations that accept on-line payments. At present only one mutual organization is part of the programme and it has a negligible number of members.

Study on funds transfers

A study of fund transfer methods was carried out in order to take stock of the information available on the subject and analyse possible options for the trial.

Surveys carried out in France and in the country of origin

Quantitative surveys were carried out among migrants in France and among families in the country of origin, in order to obtain precise data on the following: the amounts sent to families, the frequency with which they were sent, the portion of transfers allocated to health care, and information about the level of understanding and the opinion of migrants with regard to health microinsurance.

Since the migrant population as a whole is not known precisely, it is very difficult to put together statistically representative samples. This proved the main methodological problem in carrying out the surveys. Three factors need to be taken into consideration: the transient presence in France of some migrants; the fact that people move about the country according to employment or housing opportunities, or to be closer to a network of relations; and the legality of their presence in the country. The surveys prioritized legal migrants because they live in larger migrant communities, so are easier to access. Investigators were asked to identify migrants from the territory to be covered, instead of using a proper sampling process.

For Senegal, the information was gathered in France with the help of the association Fuuta Santé Matam1, who are familiar with the community. Questionnaires were collected from 584 people from a sample population recruited mainly in Ile-de-France. A mirror survey was carried out in Matam Region with the help of the same association and the local investigators it contacted. This time, 247 questionnaires were completed by families with at least one relative in France.

For Mali, the survey was carried out with the help of Mutuelle des Maliens de l’Extérieur, who provided the interviewers. A total of 437 questionnaires were completed among the Malian migrants in France. Due to accumulated delays and security problems, the Mali survey could not be completed.

For the Comoros, the survey was carried out by a Comorian based in Marseilles who had already carried out a survey on the subject in 2008, which obtained information for 181 households. Due to this investigator’s resignation, it was not possible to continue the survey.

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1 The association Fuuta santé Matam was created in December 2000 for the purpose of “promoting and improving, in the Department of Matam, health and hygiene for the benefit of the population, and to stimulate, facilitate and coordinate actions or initiatives by physical and legal persons, associations or institution, aimed at fostering the development of access to health care for the population of the Department of Matam and its region.”
The detailed reports of the surveys are available in French for each country:

- Senegal
- Mali
- Comoros

The trials

Due to the difficulties mobilizing the Comorian diaspora, it was decided to abandon the Comoros trial and to focus efforts on Mali and Senegal.

In the case of Mali, it was decided to support MME by assisting them with communication to boost the number of project participants. The project also seeks to associate the initiatives of Transport/Santé and MME more closely.

In the case of Senegal, the association Fuuta Santé Matam is strongly committed to the project, reflecting its desire to contribute to better health care for Matam families. This made it possible to carry out surveys in France (2010) and in Senegal (January 2011), as well as to set up a steering committee in France (July 2011). In January 2012, a site visit was made to Matam to collect numerical data in order to finalize the product proposition and the type of management system to be implemented locally. The survey findings were presented to stakeholders in Dakar. The trial should begin in the course of 2012, if a management system can be set up.
**Project Lessons**

**On success factors in the case studies**

Without effective communication, the success of initiatives to collect funds among migrant communities is limited. None of the initiatives documented had sufficient financial support for an ambitious communication campaign. Information provided to households and at migrant association meetings has limited impact, given that it is ad hoc and is not integrated into a long or medium-term campaign. Nonetheless, reliance on associations remains very important in order to build confidence in the project.

All the studies indicated that confidence is very important to gain migrants’ commitment. The main reasons migrants gave for not committing to the scheme were economical, but they also frequently mentioned the quality of management, health care availability locally, and confidence in the scheme. They prefer to wait for feedback from participants before committing themselves to new schemes. The quality of the information provided about the project and the reputation of the members of the migrant community involved are crucial factors in generating this confidence. It is also important that field reports on the reliability of the scheme, whether from managers or care providers, are brought to the attention of migrants. The only initiative using diaspora funds at a community (SSV) rather than at an individual level reveals that a key element in the sustainability of projects is the transparency of the use of these funds.

The quality of management in the host country and the country of origin is a prerequisite for the success of the model. If the claim-rate monitoring system is not rigorous, the project can quickly go bankrupt, as the ARIFA example shows. Good management of enrolments and premium collection, coupled with good management of health care providers in the country of origin, ensure long-term sustainability. If MME is still active after 10 years, it is because its subscribers are managed by UMC, and UTM is in charge of claims management.

It is better to build the project in partnership with existing structures rather than to create new institutions. The case of the transportation mutual association of Mali is enlightening because it was the only initiative to envisage the creation of an autonomous mutual organization under local law. Without massive membership, the heavy investments and operational costs related to this model make it unsustainable.

Health care must be accessible throughout the national territory due to the mobility of local populations and to gain more members. However, this requires a local manager with branches throughout the country.

**On funds transfers**

Informal means of transfer are still most commonly used by migrant communities, but they vary from one country to another. In Mali and the Comoros, informal transfers are most common and rely on social networks and solidarity networks (the funds can be physically transported by a member of the community visiting the home country or by a professional in return for a commission). In Senegal, informal transfer is on the decline in favour of specialized operators (MoneyGram and Western Union) and commercial banks.
On the feasibility of using migrant community funds for health insurance in Mali, Senegal and the Comoros

The majority of migrants send funds to support their community, showing a strong commitment to the development of their region. However, these transfers are less frequent than support to their immediate family (16 per cent of Malians and 50 per cent of Senegalese regularly send funds to support their community, with each transfer averaging €264 and €73 respectively). The majority of these transfers are for projects involving health improvement (54 per cent in the case of Mali, 93 per cent in the case of Senegal), in particular for the improvement or construction of health facilities in the village of origin.

Transfers by migrants to their families are frequent and large. They mainly serve to cover families' consumption needs. According to estimates, the annual amount per immigrant is €4,229 for Senegalese, with an average of 10.6 transfers per year, and €2,229 for Malians, with an average of 6.9 transfers per year. The survey in Senegal showed that these transfers are a significant source of income for families (for 61 per cent of families, it is even the main source of income). The number of dependents declared in Senegal and Mali is high, but if only spouses and children left in the country of origin are taken into account, the average number of dependents per person is four. The size of transfers is not closely correlated with the migrant’s resources, but rather with the size of the family in France and with the number of dependents in the country of origin.

The share of transfers used for health purposes would be enough to finance health insurance for four people in the country of origin. It is estimated that money transfers for health purposes amount to €557 per year on average in the case of Mali, and to €677 per year in the case of Senegal. These amounts largely surpass the €100-150 per migrant per year bracket, which would make it possible to cover four people in Mali and in Senegal. Discussion with representatives of the Senegalese migrant community suggested that a monthly contribution of €10 per migrant was conceivable. Malian members of MME pay €20 – 25 per year per beneficiary.

The majority of families' health care expenses are for primary care, and it is difficult for migrants to separate money transfers for healthcare from those for everyday consumption. This reduces the need for insurance to cover large financial shocks. Families mainly spend on medicine, medical visits and out-patient care. The surveys did not reveal many cases of money transfers for emergency or planned health care expenditures, contrary to previous assumptions that had been the basis for the belief that insurance was needed.

The everyday situation of migrants limits the project’s potential. The majority of migrants are engaged in unskilled employment and have low incomes, one third of which is devoted to housing and a significant part is sent to their families or to their community of origin. Most migrants state that they have difficulty finding the funds to satisfy request from their relatives (82 per cent for Senegal, 91 per cent for Mali), and often have to borrow from others to satisfy the needs of their families. Their daily existence is challenging, so they are reluctant to make a collective commitment and confine themselves to a limited network of acquaintances and close relatives.

On products that are attractive to migrants

The coverage needs mentioned vary from one country to another, but generally involve expenditures for primary health care. In particular, these variations are a reflection of the quality of health care services in the target zones. The main need is for payment of medicine and medical visits. In Mali, hospitalizations rank third in coverage needs, whereas the Senegalese are primarily interested in transport for health care (transfer to Dakar when families are questioned, transfer for
their families to France for the French sample), reflecting a lack of confidence in Matam's health care facilities.

**On the role of families in the success of the project**

Families in the country of origin have an important role to play in persuading migrants to **contribute to premium costs**. Families surveyed in Senegal were very interested in the project and 76.1 per cent considered it a priority, compared to only 45 per cent of Malians and 50 per cent of Senegalese. The relatives of migrants are a natural motivating factor in this kind of project, as they are able to point out priorities that migrants may not have correctly evaluated.
Next Actions

- Finalize product proposals for the trial in Senegal and convene the steering committee
- Validate the choice of risk management structure in Matam
- Present the findings of the Mali survey
- Define a communication strategy to strengthen MME’s communication efforts