Learning Journey

Centre International de Développement et de Recherche (CIDR)

Health product diversification and improvement of institutional efficiency

Contents

Project Basics

About the project

The International Development Research Institute (CIDR) is a nongovernmental organization created in 1961. Its mission is to strengthen the capacities of local institutions and informal economy micro-enterprises through activities promoting microfinance, microinsurance, service enterprises and territorial development. CIDR is currently working in 15 African countries. CIDR supports mutual health insurance programmes in eight of these.

In Guinea, CIDR has been supporting the development of mutual health insurance schemes since 1999, and the Union des Mutuelles de Santé de Guinée Forestière (UMSGF) was created in 2005. In order to enhance the autonomy and outreach of the mutual insurance organizations and the Union, CIDR began to diversify its products beyond the classic family health product. CIDR and the Union planned to create and test two new products (a safe motherhood product at village level and a product providing health coverage to students during lesson times).

The motherhood product is mandatory at the village level. If a village decides to subscribe to the product, all inhabitants must pay a premium to cover all pregnant women in that village. For the school product, enrolment is per school. Once the director and student–parent representatives agree, the cost of insurance is included in school fees. The integration of two mandatory products and, through them, greater visibility of the mutual insurance programme should contribute to the future cost-effectiveness of the Union and the mutual insurance organizations.

In addition, CIDR would like to improve the efficiency of the mutual organizations by streamlining organizational procedures and structures. In a second phase, it plans to expand the target population to the formal sector.

Project Summary

Project Name:	Health product diversification and improvement of institutional efficiency
Project Start Date:	July 2008
Duration:	3 years
Country:	Guinea
Product:	Health – primary and secondary health-care coverage

Project Updates

Key Indicators

School product

Indicators	31/12/2009	01/07/2010	01/07/2011
Number of schools subscribing	6	16	38
Number of beneficiaries	1,807	3,523	12,242
Growth rate		50%	250%
Claim ratio	43%	37%	52.3%
Renewal rate (in number of schools)		83%	69%

Safe motherhood product

Indicators	31/12/2009	01/07/2010	01/07/2011
Number of villages	8	14	16
Number of beneficiaries	1,000	4,357	8,087
Growth rate		77%	85%
Claim ratio	87%	95%	59%
Renewal rate (in number of villages)	47%	50%	94%

Family health product

Indicators	30/06/2009	30/04/2010	01/07/2011
Number of policies	2,334	2,027	2,290
Number of beneficiaries	14,355	12,273	12,528
Growth rate		-14%	2%
Claim ratio	83.2%	118%	89%
Renewal rate	n/a	n/a	55%
Penetration rate	4.6%	4.1%	4.2%

What is happening

March 2008–June 2009

A household survey and a Guinean population report revealed a high maternal and infant mortality rate, prompting CIDR and the Union to develop a safe motherhood product aimed at reducing maternal and infant mortality. It was also decided to develop a school product to cover children's health risks while at school. Target villages and schools were selected according to predefined criteria (such as the proximity of a health centre or post, the social dynamics of the village). Field surveys involving 1,410 households were carried out in order to finalize the safe motherhood product and to establish the baseline for the product impact study (a study conducted by UNFPA).

Out of the 17 villages contacted eight villages and six schools joined, representing coverage for 1,000 women of reproductive age and 1,807 pupils. Each village was given a cell phone to contact UMSGF for emergency medical transport. The general assemblies and coverage began in January 2009 in schools, and in April in villages. The population count was carried out for each neighbourhood (block) by the block chiefs, who were also in charge of collecting premiums. In some villages, village birth attendants were in charge of collecting premiums. In other cases, contributions were paid into the village treasury.

Four midwives and 54 village birth attendants were trained. The training covered screening for at-risk pregnancies, screening for high-risk delivery, and the action to take in each case.

The product includes coverage for evacuation by ambulance of women with complicated pregnancies. UMSGF operates an ambulance. This service is greatly appreciated by women in insured villages.

UMSGF has signed performance contracts with six health units. These performance contracts have been signed with health structures providing health care to women within the framework of the safe motherhood product. These contracts provide for a payment of 7000 Guinean francs (GNF) to health workers in charge of antenatal visits (ANVs) in the villages (advanced strategy), in addition to the standard national payment for each first antenatal visit.

The contracts of the six co-ordinators and three heads of zone who had been employed for many years were terminated for the Union to restructure operations. The objective of the restructuring was to give mutual organizations a sense of responsibility in their role of collecting premiums, while focusing the role of the Union on the creation of new mutual organizations and groups, and monitoring activities. Three mutual organization agents (with medical profiles) were recruited to monitor care-providers in each zone, and three marketing agents and three development coordinators were recruited for the mutual schemes which were beginning operations.

Access® management software was developed to keep track of new beneficiaries. It was not possible to implement CIDR inter-network software in Guinea because of difficult Internet connectivity.

As of 31 December 2009

The salient event in this period was the increase of health-care fees by the state (sometimes threefold), resulting in a high degree of tension between mutual organizations and health care structures, as health care structures failed to respect the provisions of the conventions signed, which imposed fixed fees for

the entire duration of the contract. A regional exploratory workshop between mutual organizations and health care structures was held, but could not find a solution concerning the fees charged to mutual organizations.

In the interest of economy, small mutual organizations of less than 300 members were merged.

Ten thousand beneficiaries were registered in the new Access system.

As of 30 April 2010

All Union agents were provided with marketing training by an independent consultant.

The family product premium campaign was behind schedule and the expended end date was moved to June. The fee increase by the state led to a sharp increase in premiums.

The Guarantee Fund had to intervene on behalf of 15 mutual organizations due to the fixed fee clause of the agreements not being respected.

Fees from the safe motherhood product were shifted from cost per individual to cost per household, with premiums ranging from GNF 12,000 to 15,000.

As of June 2010

CIDR ceased its permanent technical assistance. The teams of UMSGF were reduced by one post.

The Union acquired an ambulance for the medical evacuation of pregnant women.

Following the arrival of a new regional health director, the performance contracts between mutual organizations and health care structures were called into question and cancelled.

As of June 2011

The period 2010—2011 was marked by high inflation, a 50% decrease in the exchange rate, and as a result a significant decrease in the purchasing power of households, affecting in particular the cost of drugs available in pharmacies. The new President of the Republic also announced that obstetric care would be free, but did not give any clear indication as to how this reform would be financed.

Guinée Forestière's economic environment is undergoing profound changes: the arrival of mining companies has stimulated the job market, putting upward pressure on salaries for qualified staff. A mutual organization agent and two UMSGF marketing agents resigned in order to join the mining companies. A local nongovernmental organization, PLAN Guinée, offering a credit payment mechanism for gynaecological and obstetric care—a more attractive rival to the safe motherhood product due to the fact that it is more heavily subsidized—arrived on the scene and competes with the Union's activities.

With regard to the Union's activities in this period, new service contracts were signed: with UNICEF to support the school and safe motherhood products in the regional development communities (CRDs) of

Gouecké, Yalenzou and Péla, and, in January 2011, with UNHCR to support mutual organizations and the strengthening of safe motherhood in Kouankan and Lainè. Four new mutual organizations were created and four others merged with larger mutual organizations in order to facilitate their management by the Union.

A satisfaction survey concerning the three products offered by the Union was carried out and analysed during a CIDR site visit in June 2011. Surveys were also carried out among non-members. In all, 500 people were questioned. The findings of the survey made it possible to better evaluate the products' target populations and revealed differing profiles between salaried and non-salaried people. Non-salaried people seek financial security, whereas salaried people are drawn by the product's good cost–benefit ratio; the two groups, however, have similar preferences with regard to premiums.

Despite provision of caesareans free of charge, the price of the safe motherhood product was maintained. Only one village out of 16 did not renew its premium, and one new village joined. The premium for the school insurance product went up from GNF 2,000 to GNF 3,000.

Subscriptions to the family health product are still stagnating, due mainly to the economic uncertainties faced by the population and the political uncertainty in the country. Care providers' fee increases were not always included in premiums and 13 mutuals out of 23 are in deficit.

In keeping with its development strategy, UMSGF recruited a special assistant for six months from July to December 2010 to negotiate group coverage contracts with organized groups. The strategy adopted was to target groups with the highest incomes and to propose to them a "top range" product, giving access to a clinic offering high quality care.

These groups included:

- Public employees via the decentralized offices of the Région Forestière: ten schools and the University of Nzérékoré were contacted. At six of them, prospecting was stopped after the first contact
- Businesses: Forêt Forte S. A., a construction company named Guico Press, a bakery, a forestry enterprise and two mining companies, one at Zokota and the other at Mount Nimba
- Various associations and the tontines of the town of Nzérékoré (8)

By mid-2011, only the planters' association seemed interested in financing health coverage for its members.

Funding by the Microinsurance Innovation Facility ended in June 2011.

Project Lessons

On the product (coverage and procedures)

Safe motherhood product:

Covering delivery costs only in case of complications does not seem sufficient to guarantee the product's attractiveness and have an impact in terms of public health. On the other hand, covering all antenatal visits does not make it possible to define a product that is affordable to families. External sources of financing need to be secured. Hence, at the request of UNFPA in one of the intervention zones, the safe motherhood coverage was expanded to include antenatal visits and uncomplicated deliveries. The product as originally designed only covered emergency medical transport and complicated deliveries. The initial fee (GNF 2,000 per villager) therefore does not make it possible to cover costs. The new premium is estimated to be GNF 6,000 (USD 1.20) per inhabitant, which is not attractive for the families targeted. CIDR has proposed co-financing strategies to the Union, involving co-payment for ANVs and the search for stable sources of external funding (North/South sponsorships, state support for the project).

In the context of the mandatory product at village level, it is important to think about effective population counting methods to obtain sufficiently reliable data at a reasonable cost and reduce the risk of fraud. In the case of the safe motherhood product, the population count for the first period of coverage was carried out by asking block chiefs to count the inhabitants in their sectors, a procedure that proved to be long and ineffective (frauds were detected at the time of project follow-up). It is recommended to use the various existing population counts (tax registers, demographic censuses) and to make verifications only if significant discrepancies are noted. In order to prevent fraud, it is advisable to complete the census before beginning the awareness campaign. It is of paramount importance to define the list of women covered before coverage begins in order to avoid women from neighbouring villages "relocating" in order to be covered.

It is important to take family size into consideration in determining premiums for group products. Indeed, premium-setting of the safe motherhood per person resulted in financial difficulties for large families and it is necessary to experiment with alternatives. A per family flat-rate premium was introduced beginning with the second coverage period.

Better estimation of the time needed for premium collection would have made it possible for better planning of the collection process. The group system of management of the safe motherhood product penalizes "good payers," who have to wait until all village inhabitants have paid their contribution in order to benefit from coverage. For the fiscal year 2010-2011, the delay in premium payments allowed women to be covered for only eight months rather than 12.

School product:

The school product is easy to implement, especially in schools located near a health facility. The setting up of the school product by the Union's teams was simple and non-time-consuming.

Subscriptions to the school product were facilitated by the involvement of the Ministry of Education's representative. In the case of this project, the involvement of the prefectural director of education, in

the form of a letter of recommendation (implementation in the Prefecture of Younou) facilitated the affiliation of several schools.

Full payment of the fee by parents at the start of the school year is problematic, especially because it is combined with the payment of enrolment fees. In practice, this problem results in delayed coverage of children.

On the membership conditions and attractiveness of the products

Safe motherhood product:

Village size and the credibility of elected officials are determinant factors with regard to village affiliation. The smaller the village, the greater the social cohesion—a requirement for the success of the programme. The quality of leadership and involvement of elected officials in the project are decisive in gaining the collective membership of a village.

Villages in which community projects are being carried out seem more disposed to subscribing to the safe motherhood product. The five villages receiving assistance (renovation of the maternity unit, for example) have all joined, demonstrating that overall there is a link between the safe motherhood product and village projects. It is recommended that Union agents become involved in supporting health-related village projects.

School product:

The school product is very attractive to both parents and teachers. The satisfaction survey showed that the parents of pupils are very satisfied with the product (98%) and that teachers are significantly involved in its dissemination (72% took part in awareness-building among parents and half were involved in collecting premiums).

Family health product:

Quality of care determines the attractiveness of health insurance products. Within the context of the project, public structures often monopolised. The dramatic situation of the state budget had a serious negative impact on membership, especially with regard to the family health product, due to frequent shortages of drug supplies at health centres. Satisfaction surveys confirm this fact; 65% of members wish to see an improvement in the quality of care available and 35% of non-members interested in mutual insurance set improvement of care as the condition for joining.

On the impact of the safe motherhood product on the reduction of maternal morbidity

The coverage of ANVs and the training of village birth attendants make possible an increase in the number of deliveries attended by medical personnel, emergency transfers to hospital and caesarean deliveries, although the indictors overall are still below the national average. For the period, deliveries attended by medical personnel (not including village birth attendants) rose from 17% to 26%, the rate of emergency transfers to hospitals was 5% and the rate of caesarean deliveries was 2%, which is lower than the normal average of 5%.

The safe motherhood product's biggest impact was the reduction of maternal mortality. Two deaths out of 1,271 deliveries were recorded during the first period of coverage, giving a maternal mortality rate of 256 per 100,000, compared to a rate of 4,524 per 100,000 in the same area before the product was launched (UNFPA survey).

On the mutual economic model

The technical equilibrium of health products heavily depends on medical inflation. In the context of limited pay capacity, a major increase in medical costs places the viability of microinsurance health products in jeopardy. In the case of Guinea, the 50% increase in the cost of care could not be completely integrated. At the end of the fiscal year 2010-2012, a majority of mutuals (13 out of 23) were in deficit.

The strategy of including coverage of primary health care in the health-care package did not pay off: it did not have the desired effect on membership and was costly to the network. In 2006, due to pressure from members, primary care coverage was added to the mutual health-care product package with the objective of achieving a large increase in membership. Six years later, the outcome of this initiative is indisputable: the effect on membership was significant, but short-lived; the network's insured population increased from 16,000 to 23,000, then fell to 12,000 in 2011.The introduction of a "minor risk" guarantee raised high expectations on the part of mutual members that the health posts and centres were not able to satisfy: lack of medicine and poor reception of mutual members were the source of frustration for families and non-renewal of policies. Moreover, it introduced a consumerist rather than an insurance based mind-set among the insured, especially among salaried people, for whom security is no longer the main determinant of satisfaction (only 38% of salaried individuals mention this reason for satisfaction, compared to 58.7% of non-salaried individuals). Monitoring of care providers has become much more complex and its cost has risen. Lastly, primary-care coverage considerably increased the cost of the guarantee proposed: the public health posts and centres are the cause of the escalating claim-rate.

Distance from the health centre is a determinant factor in terms of consumption: the closer a beneficiary is to a health-care structure, the more frequent the number of visits. Among the 16 schools covered, the two located less than five minutes from a health centre have a frequency rate of 62% compared to an average of 23% for all students covered.

The school product has great potential as a viable product, with a current claim rate of 52% and low operational costs. However, the claim rate is on the upswing and needs to be monitored as knowledge of the product on the part of families and teachers evolves. Authorizations for health-care for students are issued by the school, while management surveillance is carried out by the mutual organization. There is therefore a risk of less rigorous monitoring of health-care structures and a possible negative impact on claim rates. Although an analysis of the costs associated with the dissemination and management of the product has not been done, these costs seem minor in comparison to other products proposed by mutual organizations, in particular because of the ease of putting this product into place. It is estimated that, taking into account expenses for awareness-building and follow-up, only

schools of more than 300 pupils (representing 50% of the schools in the region) are able to generate margins.

For the moment, the safe motherhood product is not cost-effective and seems to require sustained external funding to break even. The success of the safe motherhood product requires a high level of commitment on the part of Union staff and is no longer a priority, given the financial results. Although the claim rate has been brought under control, the low volumes do not make it possible to cover the extensive operating costs. It was decided to offer the safe motherhood product only in villages where the product has a high penetration rate.

The diversification of products renders the task of mutual managers more complex and makes procedures more cumbersome, in particular in terms of information flow and premium collection. Decisions need to be taken in order to dissociate the premium periods of the various products. It is necessary to define a coordinated strategy to develop the three products. The Union wishes to implement a strategy concentrating activities around these three products so as to improve the effectiveness of UMGSF staff and the input of local representatives and health centres. It would involve focusing awareness-building efforts on villages likely to subscribe to the safe motherhood product and to work together with health centres in order to achieve a global approach. For example, it is planned to negotiate with health workers visiting villages for the purposes of carrying out ANVs to also ensure curative care visits for mutual members.

With time, a mutual structure heavily dependent on volunteers and the leadership of elected officials shows its limitations. Until now, Union staff have taken on the majority of the awareness-building activities and the collection of premiums normally carried out by the mutual programme; it is however necessary to decentralize activities effectively, in particular by increasing the commissions paid to premium collectors (village managers or elected officials). It is important to pass responsibility on to the villages as soon as they join, in order to avoid the development of a “project” culture in which work is carried out by the Union. Active supporting of coordinators should only take place during the first year of the mutual’s creation.

The community model is not always synonymous with good governance. The survey carried out among non-mutual members shows that for 30% of them, factors related to the governance of mutual organizations are an obstacle to joining (60% cite the lack of information, 47% economic reasons and 21% the health-care offering).

The population’s financial capacity remains a genuine hindrance to the development of mutuals. The surveys carried out among non-members show that only 20% of them have the financial capacity to pay, thus limiting the growth potential of mutuals. In a context of high inflation, the financial pressure on households is even stronger and the payment of an insurance premium, however modest, is difficult. In such a situation of increasing premiums and diminishing purchasing power, members reduce the number of beneficiaries in their families, not being able to meet all the expenses necessary for covering all members of the family.

The sparse funding of mutual activities by donors does not make it possible for the Union to have a coherent development strategy. The various partnerships that the Union has formed with UNICEF, UNHCR and UNFPA led it to create new mutuals, to the detriment of the intensification of its activities with existing mutuals.

The strategy of contacting organized groups has not yet borne fruit, with only one group out of 25 visited being interested. Groups in Guinea are not representative enough to make a decision whether to join an insurance scheme and to ensure group management of the policy.

After ten years of activity, the mutual model in Guinea has difficulty in identifying the economic model that will allow it to achieve sustainability. At this stage of the project, it is becoming apparent that the product diversification strategy alone will not make it possible to ensure the mutual Union's viability. Despite a portfolio of over 10,000 beneficiaries, membership volumes have been stagnating for several years or even decreasing. The mutual model based on the commitment of community representatives is running out of steam and has difficulty in finding new leadership; the population's confidence in the structure is still not won and it seems that the Union must continue in the direction of professionalization.

The involvement of the state in improving the quality of care is also a fundamental criterion for the project's success. The business plans, even optimistic, indicate a need for sustained external funding of around USD 90,000 per year. Of course, the Guinean context in recent years has not been favourable to the expansion of the mutual insurance sector. But the Union must explore alternative approaches in order to continue to be able to cover vulnerable populations in Guinée Forestière and find a system of sustainable co-financing of premiums. The co-financing of premiums by mutual organizations in the North is a solution worth exploring. At present, the state is planning to introduce universal health insurance and the Union and its technical partner CIDR are key partners in defining the possible features of this universal coverage.

The Union des Mutuelles de Santé de Guinée Forestière has nonetheless succeeded in maintaining a constant presence among the population, despite the difficult international context, and has been able to bounce back in order to assure its members access to the care they need.