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, it's 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.
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.
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.