
# Health Micro-insurance

• A Compendium •

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**Strategies and Tools against social Exclusion and Poverty**
**An ILO Global Programme**

The Global Programme «Strategies and Tools against social Exclusion and Poverty» (STEP) of the International Labour Organization is an operational tool to promote the extension of social protection worldwide.

In the spirit of ILO's concrete contribution to the World Summit for Social Development (1995) and to its follow up through «Geneva 2000», the STEP Global Programme promotes the design and dissemination of alternative schemes to extend social protection to the excluded. These schemes are based on the principles of equity, efficiency and solidarity. They contribute to social cohesion and social justice.

The STEP Global Programme combines different types of activities: capitalisation, research, experimentation, production of methodological tools and conceptual works, development projects, action research, advocacy and policy dialogue.

The coordination of the production of the Compendium, together with data collection and editing have been undertaken by Shook Pui Lee.

Valuable inputs were received from the members of the STEP Team

# Introduction

As poverty and social exclusion remain major problems in the world, even as we step into the third millennium, the quest for solutions continues. The STEP Global Programme of the ILO explores innovative methods that contribute to these solutions, one of which is micro-insurance.

Micro-insurance as a concept is relatively new and its documented experiences are still fairly scarce. The STEP Global Programme thus endeavours to discover more of these experiences in an effort to evaluate their potential to reduce poverty and social exclusion.

This Compendium provides key information on 130 health micro-insurance schemes (HMIS) from 26 countries and 3 continents. It allows interested parties to obtain a broad overview of a large number of the health micro-insurance schemes that exist in the world today.

Its main aim is to serve as a facilitating tool for interested parties who want to initiate contacts with HMIS operators and developers. Therefore, special efforts were made, where possible, to include the addresses, telephone and fax numbers and email addresses of the documented schemes, hoping that it will encourage future communication between people and institutions actively involved in the field of health micro-insurance.

This Compendium is not a comprehensive guide to health micro-insurance schemes nor does it include an analysis of the different schemes presented. Likewise, the content of this Compendium is not intended to promote a preferred model of how to design, implement and manage HMIS. Finally, one should not infer STEP's policy from the content of this Compendium.

This document is a preliminary version of a database which will be published on the Internet, allowing even more people to have easy and low-cost access to annually updated information.

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# Table of Contents


***Methodology*** ***x***

***Africa*** ***1***

***Benin*** ***1***

I. L'Union Communale des Groupements Mutualistes de Sirarou and l'Union Communale des Groupements Mutualistes du Sanson ..... 1

II. La mutuelle Alafia de Gbaffo ..... 4

III. La mutuelle Ilera at Porto-Novo ..... 5

***Bukina Faso*** ***8***

I. Dakwena ..... 8

II. Mutuelle Pharmaceutique de la Santé Famille Tounouma ..... 9

***Cameroon*** ***12***

I. AFFERAZY (Association des Filles et Femmes Ressortissantes de l'Arrondissement de Zoétélé à Yaoundé) ..... 12

II. Association des Amis clan d'âge no. 13 ..... 14

III. Association des ressortissants SAWA de Yaoundé ..... 15

IV. BACUDA (BATIBO Cultural and Development Association) ..... 17

V. Mpouakone ..... 18

VI. Mupehoproma ..... 20

VII. Mutuelle Famille Babouantou de Yaoundé or Caisse de Solidarité Babouantou de Yaounde ..... 21

VIII. NSO-NGON ..... 22

IX. POOMA (Yaoundé) ..... 24

***Ghana*** ***27***

I. Dagaaba Association in Duayaw Nkwanta, Brong Ahafo region ..... 27

II. Nkoranza Community Financing Health Insurance Scheme ..... 29

III. The Proposed District Health Insurance Schemes (DHIS) ..... 31

IV. The Proposed Motauk Lafia Health Insurance Scheme ..... 33

V. West Gonja Hospital Community Financing Health Insurance Scheme ..... 35

***Kenya*** ***38***

I. Chogoria Hospital Health Insurance Scheme ..... 38

II. Tumutumu Hospital's Community-based Health Insurance, Nyeri and Kirinyaga districts ..... 40

***Mali*** ***43***

I. Centre de Santé MUTEC ..... 43

II. La mutuelle de santé du quartier de l'hippodrome à Bamako ..... 45

III. MEUMA (Mutuelle des Etudiants et Universitaires du Mali) (Mutual of students and University of Mali) ..... 45

IV. MUTAM (Mutuelle des artisans du Mali) ..... 47

V. MUTAS (Mutuelle des Travailleurs de l'Action Sociale et de la Santé) (Social and Health Workers' Mutual) ..... 47

***Senegal*** ***50***

I. Faggaru ..... 51

II. Diappo ..... 52

III. FAGGU (Mutuelle de santé complémentaire des retraités de l'IPRES) ..... 54
IV. Fandène ..... 55
V. Fissel ..... 57
VI. Gandiol Santé ..... 58
VII. Goxu Mbaaj ..... 60
VIII. Koudiadiène ..... 61
IX. Lalane Diassap ..... 63
X. Mboro ..... 64
XI. Médina Gounass ..... 66
XII. Mont Rolland ..... 67
XIII. Multi Assistance de l'Education ..... 68
XIV. Mutuelle de Yoffe or Dimeli Yoff ..... 70
XV. Mutuelle des Volontaires de l'Education ..... 71
XVI. Mutuelle Sococim Entreprises ..... 73
XVII. Ngeye Ngeye ..... 75
XVIII. Pandhienou Léhar ..... 76
XIX. Saint Jean Baptiste ..... 78
XX. Sanghé ..... 79
XXI. Soppanté ..... 81
XXII. Thially ..... 82
XXIII. Wer Werlé (Profemu), Thiès ..... 83

***South Africa*** ***85***

I. Health Insurance Scheme of HOSPERSA ..... 85
II. National Stokvels Association of South Africa (NASASA) ..... 88
III. SIZWE Medical Fund ..... 89

***Tanzania*** ***91***

I. Bumbuli Hospital's Community Health Fund ..... 91
II. Bunda Designated District Hospital's Community Health Fund ..... 92
III. Mburahati Health Trust Fund ..... 94
IV. Selian Hospital Insurance Scheme ..... 95
V. Tusaidiane Bima Ya Afya Ya Atiman ..... 97
VI. UMASIDA ..... 99

***Togo*** ***102***

I. Affaires Sociales USYNCOSTO (Union Syndicale des Coiffeuses de style du Togo) ..... 102
II. Association des Sages Femmes du Togo (Midwife Association of Togo) ..... 103
III. Djagbagba ..... 105
IV. MU-CO-TA-S-GA (Mutuelle des Conducteurs de Taxi Motos de la Station Gaitou) (Taxi drivers of Gaitou Station Mutual) ..... 107
V. MUSA – CSTT (Mutuelle de Santé – CSTT) ..... 108
VI. MUSAD (Mutuelle de Santé ADIDOADE) ..... 110
VII. Mutuelle OTP (Office Togolais des Phosphates) ..... 111

***Uganda*** ***114***

I. Ishaka Hospital Health Insurance Scheme ..... 114

II. Kisiizi Hospital Health Insurance Scheme ..... 115

III. Kisoro District and Kampala's Hospital Health Insurance Scheme ..... 117

IV. Kiwoko Hospital Community-based Health Insurance, Luweero district ..... 118

V. Nsambya Hospital Health Plan ..... 120

***Asia*** ***123***

***Bangladesh*** ***123***

I. Gonoshasthaya Kendra Health Care System's Community insurance scheme, Savar ..... 123

II. Health Card Programme of Dhaka Community Hospital ..... 127

III. Institute of Integrated Rural Development (IIRD) health insurance scheme ..... 129

IV. Rural Health Programme of Grameen Kalyan ..... 130

V. Proposed health insurance from Proshika health programme ..... 132

***India*** ***134***

I. Action for Community Organization, Rehabilitation and Development (ACCORD) ..... 134

II. Association for Sarva Seva Farms (ASSEFA), Hyderabad ..... 135

III. Cooperative Development Foundation (CDF) ..... 136

IV. Integrated Social Security Scheme of SEWA ..... 137

V. The Society for Promotion of Area Resource Centres (SPARC) ..... 139

***Nepal*** ***141***

I. Emergency funds of local solidarity/ Self-Help Groups ..... 141

II. Maternity Benefit Scheme of Vijaya Youth Club Credit Union, Newalparasi District ..... 141

III. Maternity Benefit Schemes of local mothers' groups. ..... 142

IV. Medical Insurance Scheme of Lalitpur area of United Mission in Nepal ..... 142

***Philippines*** ***146***

I. Angono Credit and Development Co-operative (ACDECO) ..... 147

II. Bukidnon Health Insurance Programme (BHIP) ..... 149

III. Community Health Care Project of Guihulngan District Hospital, Negros Oriental, Region VII: Peso For Health ..... 153

IV. Co-operative Health Emergency Assistance Programme (CHEAP) ..... 154

V. Federation of Barangay Health Workers (BHWs) of Surigao del Norte's Health Insurance ..... 155

VI. Guimaras Health Insurance Programme (GHIP) ..... 155

VII. HEWSPECS Pilot Community Based Health Maintenance Organization (CBHMO) ..... 158

VIII. Linabo Parish's Medical Health Care Insurance Programme for Students ..... 159

IX. Lunas Damayan – Bagong Silang Primary and Multi-Purpose Cooperative ..... 160

X. Lunas Damayan – Pagkakaisa ng Kababaihan ..... 162

XI. Lunas Damayan – Pandayan Multi-Purpose Cooperative ..... 164

XII. Maibo Bulig-Bulong Programme (MBBP) in South Cotabato ..... 165

XIII. Medical Mission Group Hospitals & Health Services Cooperative (MMGHHS) ..... 166

XIV. Medicare Programme II Project, Sampaloc, Quezon ..... 167

XV. Medicare Programme II Project, Unisan, Quezon ..... 168

XVI. Novaliches Development Cooperative, Inc. (NOVADECI)..... 170
XVII. ORT Health Plus Scheme (OHPS) in La Union..... 172
XVIII. San Isidro Medicare II Project..... 176
XIX. Silago Multi-Purpose Co-operative's Coop Medical Aid Plan..... 177
XX. Tarlac Health Maintenance Programme..... 177
XXI. Tribal Women's Health Project..... 179
***Thailand*** ***180***
I. Klong Pia Credit Union in Songkla..... 180
II. Sri Haruethai Klung Credit Union..... 181
***Latin America*** ***183***
***Argentina*** ***183***
I. Obra Social Municipal - Municipalidad de Trenque Lauquen..... 183
II. Servicio de Salud - Asociación Mutual S.M. Laspiur..... 185
***Bolivia*** ***187***
I. Mutual de Seguro de Salud - CIMES..... 187
II. Seguro Universal de Salud - IPTK..... 188
***Colombia*** ***191***
I. Empresa Solidaria de Salud - AMUANDES..... 191
II. Empresa Solidaria de salud- COOPSALUD..... 193
III. Empresa Solidaria de Salud - ECOMAR..... 195
IV. Empresa Solidaria de Salud - ECOOPSALS..... 197
V. Empresa Solidaria de Salud- AMAR..... 199
VI. Empresa Solidaria de Salud - Co-Esperanza..... 200
***Dominican Republic*** ***203***
I. Seguro para servicio de consultas fijas y ambulatorias - Asociación Mutual de los Trabajadores de los Bateyes (AMUTRABA)..... 203
***Ecuador*** ***205***
I. Seguro Comunitario SOLANO – Comité de salud del subcentro de Salud Solano..... 205
II. Seguro Familiar - FEPP..... 206
III. Seguro Social Popular – Sistema Comunitario de Salud Integral (SICSI)..... 208
IV. Sistema Solidario de Asistencia Médica – Salud Mutual..... 210
***Guatemala*** ***213***
I. Servicio Solidario de Salud - CGTG..... 213
II. Convenio Familiar de Salud - ASSABA..... 214
III. Fondo de Solidaridad Social - ACSMI..... 216
***Nicaragua*** ***218***
I. Seguro de Salud Universal - ATC..... 218
***Peru*** ***220***
I. Seguro del Agricultor – Municipalidad Sama Las Yaras..... 220
II. Seguro del Agricultor – CLAS de la Municipalidad de Ite..... 221
***Uruguay*** ***224***
I. Policlínica Unica José Pedro Varela – Complejo de Cooperativas de Vivienda José Pedro Varela 224
***Venezuela*** ***226***
I. Sistema Autogestionario de Servicios de Salud – Cooperativa Los Naranjos..... 226

# Methodology

## 1. Identification of schemes

Firstly, we identified persons and institutions involved in the development and management of and/or provision of technical assistance to HMIS. Thereafter, we contacted key players to enquire about their activities related to health micro-insurance. Finally, information was compiled either by means of completed standard questionnaires or through consultation of relevant documentation.

At the same time research was conducted by reviewing selected literature, contacting ILO personnel — both at headquarters and at regional offices, researchers and academic institutions active in the field of social protection and by searching the Internet.

## 2. Health micro-insurance schemes: selection criteria

In order to decide which of the schemes identified should be included in this Compendium, STEP developed a number of criteria. It should be noted that the criteria described below do not imply a fully-fledged definition of HMIS. Rather they were developed for selection purposes only and thus as a tool to limit the search to certain types of schemes of interest to STEP at this stage.

1st criterion:

> *The scheme uses an insurance mechanism, i.e. a financial instrument which, in return for payment of a contribution (or premium), provides members with a guarantee of financial compensation or service on the occurrence of specified events. The members renounce ownership of the contributions that they make. These are primarily used to meet the cost of the benefits.*

*Explanation:*

- The insurer collects a fixed amount of contribution, normally called a premium, (either monetary or non-monetary - services or in kind - with an equivalent monetary value) at regular intervals of time, in exchange for a guarantee to provide monetary compensation or services when a specified event has occurred and the insured has suffered a loss, which could be monetary or non-monetary (the integrity and quality of a person's life in a given society[1]).
- The insured renounce ownership of the premium paid.
- The premium is used for the insurer's on-going operations, whereby a significant proportion of the premium will be used for the purpose of meeting potential claims by those insured during the period when the insurance contracts are explicitly or implicitly effective.
- Before setting an appropriate amount of premium for the insurance contract, the insurer will estimate the potential number of claimants, and the size of their claims during the insurance period, out of the number of insured members the insurer could potentially recruit.
- Private and/or public sources may subsidise the real cost of the premium as well as the operation of the insurance.

[1] e.g. psychological health, social reputation

**The following types of scheme should be excluded:**

**i) Health savings or credit schemes that do not include an insurance function.**
**ii) Prepayment schemes administered by service providers who do not operate an insurance scheme. This applies particularly when there is no financial and administrative separation of health care provision and prepayment (i.e. where the contributions are not used to pay directly for the benefits but are simply one component of the service provider's income).**

*Explanation:*

- Prepayment schemes without risk sharing, which allow members to claim an amount of money or service that is equivalent to the amount prepaid during a defined period, cannot be considered insurance. The same applies to savings and credit schemes.

2nd criterion:

*Members or beneficiaries of the insurance scheme contribute to the financing of the benefits, at least partially, from their personal income.*

*Explanation*

No minimum amount of contribution of members (beneficiaries) is fixed. The financing method of the scheme is one of the items of information required for the identification of a micro-insurance scheme.

3rd criterion:

*Beneficiaries of the scheme are insured on a voluntary or automatic basis — in the latter case through an existing agreement with a group or organization of which they are also members — and not on a compulsory basis.*

*Explanation:*

- Voluntary membership means that people are free to become a member of the scheme. Membership is automatic when belonging to a group or organization (co-operative, village, trade union, etc.) results in membership of a micro-insurance scheme. A condition is, however, that this automatic membership is the result of a group decision, and not imposed from outside. It also implies that if a member of the group or organization decides to terminate his/her membership of that entity, then he/she will no longer enjoy automatic membership of the related micro-insurance scheme.

- All compulsory schemes have been excluded.

4th criterion:

*Most of the beneficiaries of the scheme are, in practical terms (averaged over a calendar year), excluded from existing (statutory) social security services and/or have an income at or below the national poverty line.*

- For large-scale schemes, as a guideline, the target number of beneficiaries excluded from social security services or belonging to low-income groups is 1,000 people. For a small-scale scheme this would be 20-25% of the total number of beneficiaries.

5th criterion:

*Beneficiaries or insured members are associated with, or involved in the management of the scheme, that is to say, at least in the choice of the health services it covers.*

*Explanation:*

- The opinions expressed by insured members and beneficiaries through formal or informal consultation carried out by the insurer need to have a significant impact on the choice of elements covered by the insurance contract. Although not obligatory, it is an advantage if the beneficiaries or insured members are involved in the decision-making process, be it through a form of association that includes voting rights or actual participation in the regular management of the scheme.

6th criterion:

*The scheme is established outside the statutory social security system, by an entity that could be either public or private.*

*Explanation*

- The scheme could have been set up and managed by a number of different partners. They include trade unions, private sector, international development agencies and non-governmental organizations. In exceptional cases, like the non-statutory Medicare Programme II in the Philippines, government agencies are involved in setting up and running voluntary health micro-insurance programmes in the provinces. Such cases are included in the Compendium.

## 3. Quality control of information

On receiving key information on the HMIS identified, STEP regional staff verified the initial data obtained using a specially designed checklist and the HMIS selection criteria described above. They subsequently reported back on the methods used (e.g. contacting key person, reviewing literature etc.) during the verification process and advised whether or not a particular case could be included in the Compendium.

At the same time, efforts were made to verify the descriptions of certain HMIS with their operators.

In spite of the painstaking and extensive efforts made to obtain full information from as many reliable sources as possible, STEP has not in all cases been able to check the data collected. It can, therefore, not fully guarantee the quality and reliability of the data given in this Compendium. In addition, it should be noted that in some cases it has proved impossible to obtain the latest information.

## 4. Presentation of the information

The presentation of the Compendium is organized according to three geographical regions, Africa, Asia and Latin America. For each region countries are listed in alphabetical order, as are schemes within each country.

Information on most of the schemes is presented in the format shown below, while for others only a brief description is provided.

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   **Address (state country):**
   **Telephone:**
   **Email:**
   **Fax:**

3. **Contact person:**

4. **Type of organization responsible for the HMIS:**
   - mutual benefit society
   - co-operative-type organization
   - association
   - other community organization
   - commercial health care provider
   - non-profit health care provider
   - trade union
   - other: give details

5. **Year (and month) when the scheme was (formally) set up:**

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:**

7. **Total number of male/female members of the scheme:**

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:**

10. **Proportion of beneficiaries a) excluded from other social security systems or b) with income below the poverty line:**
    - between 25 and 50%
    - more than 50%
    - if less than 25%, number of beneficiaries excluded or below the poverty line

11. **Place of residence for the majority of members:**
    - rural area
    - urban area
    - urban surrounding

12. **Geographical area covered by the health micro-insurance scheme:**
    - commune/village
    - department
    - province/region
    - national

**13. Type of basic health care services covered by the scheme:**

preventive care and health promotion
out-patient care
hospital treatment
midwife services/ reproductive health care
medicines
medical evacuations
other:

**14. Method of financing the health insurance:**

members' contributions
voluntary contributions by non-members and other organizations
state contribution
non-state subsidies from development agencies, donors etc.
other:

**15. Members' participation in the management of the scheme:**

democratic administration of the scheme by members (general assembly)
members' involvement in the organization responsible for the administration of the health micro-insurance scheme
administration by the organization responsible for the administration of the HMIS without members' participation other than choice of health services covered.

**16. Technical assistance**

receives regularly external technical assistance
receives punctual external technical assistance as required
does not receive external technical assistance

If receiving external technical assistance, please indicate the name of the institution or the position(s) of the individuals providing these services.

**17. Other (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses, etc.:**

**-Any bibliographical and written references:**

**-Names of persons and/or organizations that can provide additional information about the scheme:**

# Africa

# Benin


I. L'Union Communale des Groupements Mutualistes de Sirarou and l'Union Communale des Groupements Mutualistes du Sanson

II. La mutuelle Alafia de Gbaffo

III. La mutuelle Ilera at Porto-Novo


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## I. L'Union Communale des Groupements Mutualistes de Sirarou and l'Union Communale des Groupements Mutualistes du Sanson

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** L'Union Communale des Groupements Mutualistes de Sirarou and l'Union Communale des Groupements Mutualistes du Sanson

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**

3. **Contact person:**
   UCGM Sirarou: Souno Karim, President,
   UCGM Sanson: René Bio-Lafia, Treasurer; Sare Issoufou, Accountant

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society: they are mutual health organizations

5. **Year (and month) when the scheme was (formally) set up:** 1995

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:**

7. **Total number of male/female members of the scheme:** UCGM Sirarou: 3,079 (1996), some 24% of the target population; UCGM Sanson: 584 (1996), some 8% of the target population.

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** UCGM Sirarou: 3,079 (1996), some 24% of the target population; UCGM Sanson: 584 (1996), some 8% of the target population.
(Target population: for UCGM Sirarou, it is the estimated 13,000 villagers living in Sirarou ; for UCGM Sanson, it is the estimated 7,300 villages living in the Sanson commune.

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
**X** more than 50%

11. **Place of residence for the majority of members:**
**X** rural area: both Sirarou and Sanson

12. **Geographical area covered by the health micro-insurance scheme:**
**X** commune/village

13. **Type of basic health care services covered by the scheme:**
**X** hospital treatment: 100% for hospitalisation
**X** midwife services/ reproductive health care: 100% for deliveries
**X** others: 100% for snake bite
Note: the benefit package of both UCGM Sirarou and Sanson are identical. Both have a community health centre and a health post that treat snake bites and handle deliveries. For hospitalisation, however, insured members will have to go to St. Jean de Dieu Hospital.

14. **Method of financing the health insurance:**
**X** members' contributions

Note: (as of October 1997)

| Membership category | Annual premium (F CFA) |
|---|---|
| Individual | 1,300 |
| Family with 2 to 5 members | 3,700 |
| Family with 6 to 10 members | 7,500 |
| Family with 11 to 15 members | 12,400 |
| Family with 16 or more members | 18,000 |

15. **Members' participation in the management of the scheme:**
**X** democratic administration of the scheme by members (general assembly): insured members can participate the monthly meeting conducted at the village level and at the communal level.

16. **External technical assistance**
**X** receives regular external technical assistance: these two mutuals, along with the other 7 mutual associations in the south of Borgou, continue to receive regular technical support from CIDR. These supports include the establishment of an administrative structure and an accounting system, carrying out promotional activities and promoting public awareness.

17. **Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
L'Union Communale des Groupements Mutualistes de Sirarou and l'Union Communale des Groupements Mutualistes du Sanson are just two of the 9 health mutuals at the South of Borgou that were set up by Centre International de Developpement et de Recherche (CIDR) with financial support from Coopération Suisse.

These 9 health mutuals are organised around a grouping of 28 villages. In 1996, they provide health care coverage to 7,400 beneficiaries, who are mainly farmers and their family members.

It was the former director of St. Jean de Dieu Hospital, now the executive secretary of l'Association des Œuvres Médicales Privées Confessionnelles et Sociales au Bénin (AMCES) who requested for support in implementing mutual health insurance schemes at the south Borgou region. This explains why there is a strong link between the mutuals and St. Jean de Dieu Hospital.

The mutual health organization is organised on two levels. The insured village members from the same village group come together and form Groupements Mutualistes du Village (GMV). Then, each GMV elects from among the members its president, treasurer and secretary. When all the GMV in an area (commune) groups together, it forms the UCGM.

Some of the advantages of these health insurance schemes:

- There is strong internal solidarity at both the village level and communal level
- Regular and free discussions at the meeting encourage management transparency and give confidence to the insured members on the insurance scheme
- Premium rates are designed to encourage family membership
- Premium collection is carried out during the cotton selling period
- If a member cannot afford to pay his/her premium in one time, the GMV can provide a credit facility that will allow him/her to pay in instalments. GMV will then become the guarantor to UCGM. Since there is tight social control down at the village level, default payment is not a worry anymore. In contrary, this facility allows flexibility to those who genuine needs it.

An innovative arrangement for these two mutual health insurance schemes is the maintenance of two funds. One is used to provide loans to insured members who have difficulties in paying for treatments that are not covered by the insurance scheme. Repayments can be spread out over time. The other fund is used to help to pay for health care services of the indigent, poor or handicapped villagers who cannot afford to pay the annual health insurance premiums. Both funds intend to reinforce the solidarity among insured members and between insured members and non-insured members in the villages.

Both health insurance schemes enjoyed surplus during their 1996 financial year.

**-Any bibliographical and written references:**
Dr. Diop, F. P. (1998) *Etudes de cas de mutuelles de santé au Bénin. ILO/STEP, ILO/ACOPAM, USAID/*PHR, *ANMC, WSM*. A copy of this case study can be obtained from STEP. Please contact Ms. Victoria Giroud-Castiella. Tel: +41-22-799 6072. Fax: +41-22-799 6644. Email: giroud@ilo.org

**-Names of persons and/or organizations that can provide additional information about the scheme:**
For more information, please go to http://www.concertation.org

## II. La mutuelle Alafia de Gbaffo

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** La mutuelle Alafia de Gbaffo

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**

3. **Contact person:** Dedokoton Seraphin, President; Kanlisou Guillaume, Treasurer; Alakatou Adolphe, Secretary.

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society: mutual health organization

5. **Year (and month) when the scheme was (formally) set up:** 1995

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:**

7. **Total number of male/female members of the scheme:** less than 100

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** less than 100 (Target population: 2,000 population living in Gbaffo village and population in its surrounding 5 villages. Most of them are farmers)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    **X** more than 50%

11. **Place of residence for the majority of members:**
    **X** rural area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village

13. **Type of basic health care services covered by the scheme:**
    **X** out-patient care: consultation
    **X** hospital treatment: surgery and hospitalisation

14. **Method of financing the health insurance:**
    **X** members' contributions

15. **Members' participation in the management of the scheme:**
    **X** members' involvement in the organization responsible for the administration of the health micro-insurance scheme

16. **External technical assistance**
    **X** does not receive external technical assistance

17. **Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
This mutual was set up under the initiative of a regional hospital's director and the personnel of a community health centre.

After the initiative of Bamako was implemented, the personnel of the community health centre attributed the reduced number of patients of the centre to service fees charged for health care services. To facilitate greater access to health care, they experimented with the possibility of lending money to patients who could not afford to pay for health care treatments. But subsequent payment defaults have urged the initiators to draw up a mutual health insurance scheme as an alternative financing method for the local people to gain greater accessibility to health care services. However, the founders are lack of experience in implementing and managing health insurance. They also did not receive any technical and financial assistance on this venture.

Weaknesses of this mutual health insurance scheme:

- Lack of experience and knowledge on mutual health insurance
- Without external support at the very beginning
- Limited coverage of the health insurance. The scheme is designed to cover only adults in the Gbaffo village. The men are insured as individual, but children and the old people are excluded, because the latter group may use more of health care services than the former group and this would have financial implication on the sustainability of the insurance system. However, this exclusion could potentially worsen the health condition of children and old people.
- Increase migration of adult men from villages to urban cities. Hence not only did the population of the already relatively modest size villages shrinks even further, those who were left behind were the very young and old who are excluded from the health insurance scheme.

As with the case of mutual Ilera, the very existence of mutual Alafia depended on the personal charisma of the director of the regional hospital. After he was replaced by another doctor, who did not show any interest in the mutual health scheme, the survival of the insurance scheme was threathened. Since then, it has encountered difficulties in attracting more memberships from its target population.

The mutual has suspended its operation after the departure of the former regional hospital director and the organization is trying to convince the present director to use the regional hospital as a referral centre.

**-Any bibliographical and written references:**
Dr. Diop, F. P. (1998) *Etudes de cas de mutuelles de santé au Bénin. ILO/STEP, ILO/ACOPAM, USAID/*PHR*, ANMC, WSM*. A copy of this case study can be obtained from STEP. Please contact Ms. Victoria Giroud-Castiella. Tel: +41-22-799 6072. Fax: +41-22-799 6644. Email: giroud@ilo.org

**-Names of persons and/or organizations that can provide additional information about the scheme:**
For more information, please go to http://www.concertation.org

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# III. La mutuelle Ilera at Porto-Novo

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** La mutuelle Ilera

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   **Address:** Porto Novo
   **Telephone:** +229-22 50 30 (Porto Novo) or 30 21 54 (Cotonou)

3. **Contact person:**
   Frédérik QUIST, President ; Manzour Chouahibou, office member; Saizonou Sianath, office member; Houndegla Aline, administrator.

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up:** 1996

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:**

7. **Total number of male/female members of the scheme:** 11

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 43 (Target population: all residents of Porto Novo)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** urban surroundings

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village

13. **Type of basic health care services covered by the scheme:**
    **X** out-patient care: 20% of the cost of consultation
    **X** midwife services/ reproductive health care: 60% of the cost of delivery
    **X** medicines: 50% of the cost
    **X** others: 30% of the cost of medical test
    Note: the health care service provider is St. Sébastien clinic, which adheress to the social orientation of the mutual association.

14. **Method of financing the health insurance:**
    **X** members' contributions: membership fee is 1,000 CFA Franc; monthly premium for a subscriber is 1,000 CFA Franc and monthly 100 CFA Franc as supplementary for spouse(s) and children.

15. **Members' participation in the management of the scheme:**
    **X** democratic administration of the scheme by members (general assembly) General assembly, governing body and office meet regularly. The mutual does not have control committee.

**16. External technical assistance**

**X** does not receive external technical assistance

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

This mutual was set up under the initiative of a doctor at the regional hospital of Porto-Novo and a group of teachers of the same area.

The scheme has encountered difficulties since its inception. A month after the general assembly, the doctor who initiated this health insurance scheme left Porto-Novo for further studies. The whole scheme was grounded on the confidence of the local people on his reputed humanitarian qualities and excellent medical performance. Hence, after his departure, it was very difficult for the mutual health organization to attract more memberships from its target population.

After the failure of the health centre that it has had agreements, this mutual has not started its activites.

**-Any bibliographical and written references:**

Dr. Diop, F. P. (1998) *Etudes de cas de mutuelles de santé au Bénin. ILO/STEP, ILO/ACOPAM, USAID/*PHR, ANMC, WSM. A copy of this case study can be obtained from STEP. Please contact Ms. Victoria Giroud-Castiella. Tel: +41-22-799 6072. Fax: +41-22-799 6644. Email: giroud@ilo.org

Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by*. ILO/STEP, ILO/ACOPAM, USAID/PHR, ANMC, WSM*. Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

For more information, please go to http://www.concertation.org

# Bukina Faso

I. Dakwena

II. Mutuelle Pharmaceutique de la Sainte Famille Tounouma

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## I. Dakwena

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**
***Address:*** 01 BP 1446, BOBO DIOULASSO 01
***Telephone:*** +226-98 21 52
***Fax:*** +226-98 01 90

**3. Contact person:**
Rémy SANOU, President
Michel Sogossira SANOU, Manager

**4. Type of organization responsible for the HMIS:**
**X** mutual benefit society

**5. Year (and month) when the scheme was (formally) set up:** June 1991

**6. Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 1995

**7. Total number of male/ female members of the scheme:** 125

**8. Total number of members in the organization that has set up the scheme:**

**9. Total number of current male/ female beneficiaries of the scheme:**625 (Target population: all interested parties. The mutual covers 5 areas, having around 10-15,000 persons)

**10. Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
Information not available

**11. Place of residence for the majority of members:**
**X** rural area
**X** urban area
**X** urban surroundings

**12. Geographical area covered by the health micro-insurance scheme:**

**X** department

**13. Type of basic health care services covered by the scheme:**

**X** outpatient care: consultation 50%

**X** hospital treatment 50%, minor/major surgery 50%

**X** midwife services/ reproductive health care: delivery 50%

**X** medicines 50%

**X** others: radiology/laboratory test 50%, dental treatment 50%

Note: direct payment by insurer covers up to 50% for all health services provided by the mutual's dispensary. For health services availed outside the mutual, members may claim a 50% reimbursement.

**14. Method of financing the health insurance:**

**X** members' contributions: 1,000 CFA Franc membership fee and 200 CFA Franc for a subscriber card; yearly premium of 4,000 CFA Franc per family is payable in monthly or half-yearly instalment. Family comprises of the subscriber, a spouse and the children.

**15. Members' participation in the management of the scheme:**

**X** democratic administration of the scheme by members (general assembly): General assembly, the governing body, the control committee meet frequently. The mutual has an office and is managed by 6 permanent volunteers.

**16. External technical assistance**

Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

This mutual was created with an ethnic base, but it progressively opens up its membership to all inhabitants in the area, while retaining the cultural and collective identity of its members. It seems relatively well managed but it does not have accounts document nor does it conducts financial analysis.

It experiences difficulties in recruiting new subscribers and in collecting premiums (the majority of the members are peasants with irregular income).

In the long-term, the mutual plans to set up a co-operative.

**-Any bibliographical and written references:**

Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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## II. Mutuelle Pharmaceutique de la Santé Famille Tounouma

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** Paroisse de TOUNOUMA

3. **Contact person:**
   Alfred SANOU, President
   Patrice SANOU, Manager

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up:** 1985

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 1985

7. **Total number of male/ female members of the scheme:** 1576

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** Around 15,000 (Target population: any interested parties)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** urban area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village

13. **Type of basic health care services covered by the scheme:**
    **X** medicines: generic medicine: around 2/3 of the retail price.

14. **Method of financing the health insurance:**
    **X** members' contributions: 1,000 CFA Franc membership fee, and yearly premium of 2,000 CFA Franc per family. Family comprises of subscriber, the spouse(s), the children and direct ascendants
    **X** others: Medicine and cash donations in 1994

15. **Members' participation in the management of the scheme:**
    **X** administration by the organization responsible for the administration of the HMIS without members' participation other than choice of health services covered: The committee of Social Action of the parish, which is a grouping of several company benefit schemes (Œuvres Sociales) on behalf of pharmacy, bookshop, cimetry, charities and young women dressmaking centre, holds meeting for the mutual. The Mutuelle Pharmaceutique de la Santé Famille Tounouma employs two sales persons.

**16. External technical assistance**

Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

The service provided by this mutual is limited to supplying generic medicines at low price. Hence, it functions more like a co-operative than a mutual.

It experiences serious financial difficulties, notably on unpaid premiums from members. Moreover, it does not have a system to regulate the identity of beneficiaries. Medicines are either sold to non-insured members or sold without prescriptions. Furthermore, it does not carry out regular stock check and as a result, experiences difficulties in getting supplies.

In 1995, it was reported to have financial surplus, but the the information is still subject to verification. The mutual does not appear to function automously and it is possible that it is supported by other company benefit schemes.

**-Any bibliographical and written references:**

Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by. *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

# Cameroon

I. Afferazy (Association des Filles et Femmes Ressortissantes de l'Árrondissement de Zoétélé à Yaoundé)

II. Association des Amis clan d'âge No.13

III. Association des ressortissants SAWA de Yaoundé

IV. BACUDA (BATIBO Cultural and development Association)

V. Mpouakone

VI. Mupehoproma

VII. Mutuelle Famille Babouantou de Yaoundé or Caisse de Solidarité Babouantou de Yaounde

VIII. NSO-NGON

IX. POOMA (Yaoundé)

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## I. AFFERAZY (Association des Filles et Femmes Ressortissantes de l'Arrondissement de Zoétélé à Yaoundé)

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** BP 1 600 YAOUNDE
   ***Telephone:*** +237-22 22 50
   ***Fax:*** +237-22 22 50

3. **Contact person:**
   Berthe MVIE MEKA, President

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society: traditional type

5. **Year (and month) when the scheme was (formally) set up:** March 1997

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** March 1997

7. **Total number of male/ female members of the scheme:** 67

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** No official record, but estimated at around 300 (Target population: all women with Zoétélé origin and all women marry into Zoétélé families, under the condition that they respect the rules and regulations of the mutual)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
Information not available

11. **Place of residence for the majority of members:**
- **X** rural area
- **X** urban area
- **X** urban surroundings

12. **Geographical area covered by the health micro-insurance scheme:**
- **X** commune/village

13. **Type of basic health care services covered by the scheme:**
- **X** hospital treatment: hospitalisation (accommodation and health care) is 10,000 CFA Franc; major surgery is 10,000 CFA Franc
- **X** midwife services/ reproductive health care

14. **Method of financing the health insurance:**
- **X** members' contributions: membership fee is 500 CFA Franc; annual premium for a family is 12,000 CFA Franc. Family members are: the subscriber, a spouse, the children, and direct ascendants.

15. **Members' participation in the management of the scheme:**
- **X** democratic administration of the scheme by members (general assembly) general assembly, office and control committee meet regularly. The mutual does not have an office. It is managed by 8 temporary volunteers.

16. **External technical assistance**
Information not available

17. **Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

The local origin of the mutual's members reinforces their mutual solidarity (a strength of traditional mutual over social mutual). A representative controls effectively the identity of patients at the hospital.

Only a part of the benefits fits into the criterias of a mutual. In fact, in numerous cases, it has requested its members for mutual assistance: for example , for childbirth delivery, a supplementary premium is systematically withdrawn (500 or 1,000 CFA Franc) from its members to honour the benefit.

**-Any bibliographical and written references:**

Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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## II. Association des Amis clan d'âge no. 13

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** BP 862 YAOUNDE

3. **Contact person:**
   Fridolin KAMGANG, President and Manager

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society: traditional type

5. **Year (and month) when the scheme was (formally) set up:** 1991

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 1991

7. **Total number of male/ female members of the scheme:** 45

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** Not evaluated (around 200) (Target population: all Batié national living in Yaoundé)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** urban area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village

13. **Type of basic health care services covered by the scheme:**
    **X** hospital treatment: hospitalisation (accommodation and health care) is paid 25,000 CFA Franc; major surgery is paid 25,000 CFA Franc
    **X** midwife services/ reproductive health care: delivery is paid 25,000 CFA Franc
    Note: benefits are paid in lump-sum

14. **Method of financing the health insurance:**

- **X** members' contributions: membership fees are variable; yearly premium for a family is 5,200 CFA Franc, which is 100 CFA Franc per week. Family members are: the subscriber, the spouse(s) and the children.
- **X** others: interests from saving account

**15. Members' participation in the management of the scheme:**

- **X** democratic administration of the scheme by members (general assembly)**:** general assembly, governing body and office meet regularly. It does not have a control committee, neither an office.

**16. External technical assistance**

Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

The financial plan of the mutual seems to be relatively better managed than its administrative plan. All members pay their premiums and there is no late payment. A delegation systematically verifies the identity of patients who are treated in the hospital.

**-Any bibliographical and written references:**

Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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## III. Association des ressortissants SAWA de Yaoundé

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**

***Address:*** s/c Pierre BILLE MBANGUE, BP 91 YAOUNDE
***Telephone:*** s/c +237-23 38 11, 23 22 01

**3. Contact person:**

Pierre BILLE MBANGUE, President

**4. Type of organization responsible for the HMIS:**

- **X** mutual benefit society: traditional type

**5. Year (and month) when the scheme was (formally) set up:** 1994

**6. Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 1994

**7. Total number of male/ female members of the scheme:** 15

**8. Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** Not evaluated (around 100) (Target population: all SAWA nationals living in Yaoundé)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
Information not available

11. **Place of residence for the majority of members:**
**X** urban area

12. **Geographical area covered by the health micro-insurance scheme:**
**X** national

13. **Type of basic health care services covered by the scheme:**
**X** hospital treatment: hospitalisation (accommodation and health care) is paid 75,000 CFA Franc; surgery is paid 75,000 CFA Franc
**X** midwife services/ reproductive health care: delivery is paid 60,000 CFA Franc
Note: Benefits are paid in lump-sum.

14. **Method of financing the health insurance:**
**X** members' contributions: membership fee is 1,000 CFA Franc; monthly premium for a family is 1,000 CFA Franc. Family members are: the subscriber, one spouse, the children and direct ascendants.

15. **Members' participation in the management of the scheme:**
**X** democratic administration of the scheme by members (general assembly): general assembly, office and control committee meet regularly. The mutual does not have an office and is managed by 5 temporary volunteers.

16. **External technical assistance**
Information not available

17. **Others (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
This mutual has dynamic members, especially among the women. But it does not have proper accounting and lacks of subscribers. It is also lack of funds, as the majority of subscribers are unemployed.

**-Any bibliographical and written references:**
Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

# IV. BACUDA (BATIBO Cultural and Development Association)

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** s/c Henry W. MBA, Department of Human Resource, Ministry of Agriculture

3. **Contact person:**
   Henry W. MBA, President and Manager

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society: traditional type

5. **Year (and month) when the scheme was (formally) set up:** at least since 1994

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** at least since 1994

7. **Total number of male/ female members of the scheme:** 171

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 250 (Target population: all BATIBO boys and girls)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** urban area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** national

13. **Type of basic health care services covered by the scheme:**
    **X** hospital treatment: hospitalisation (accommodation and health care); major surgery
    **X** midwife services/ reproductive health care: delivery
    Note: Every time when the mutual has to intervene, a supplementary premium of 2,000 CFA Franc per subscriber is withdrawn. Hence, the amount of benefits varies depending on the amount collected. Only those who pay the annual 2,000 CFA Franc premium would be covered.

14. **Method of financing the health insurance:**
    **X** members' contributions: membership fee of 200 CFA Franc; yearly premium for a family is 2,000 CFA Franc. Family members are: the subscriber and the children.

15. **Members' participation in the management of the scheme:**

**X** democratic administration of the scheme by members (general assembly): general assembly meets regularly; executive office is invited when it is necessary; the mutual does not have a control committee. It does not have an office and is managed by 10 temporary volunteers.

**16. External technical assistance**
Information not available

**17. Others (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
This establishment does not fit exactly the descriptions of a mutual. Although it collects an annual premium of 2,000 CFA Franc to entitle its members to the covered benefits, the benefits are actually paid out of the supplementary payment (2,000 CFA Franc per subscriber) that are withdrawn from members every time the mutual has to make a benefits payment. In essence, the mutual functions like a mutual aid association.

This mutual experiences management difficulties. It lacks of transparency and competence in financial management, and suffers from unsatisfactory premium collection rate .

**-Any bibliographical and written references:**
Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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## V. Mpouakone

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**
***Address:*** s/c Madam VARERIKIATOU, Minefi/DPD, YAOUNDE
***Telephone:*** +237-22 36 22

**3. Contact person:**
Awa NJUDEM, President
Amina BAKO, Manager

**4. Type of organization responsible for the HMIS:**
**X** mutual benefit society: Traditional type

**5. Year (and month) when the scheme was (formally) set up:** May 1996

**6. Year (and month) when the scheme began to deliver the first benefits to beneficiaries:**
May 1996

**7. Total number of male/ female members of the scheme:** 40

**8. Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** Around 200 (Target population: all women of Noun national (province at the west))

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
Information not available

11. **Place of residence for the majority of members:**
**X** urban area

12. **Geographical area covered by the health micro-insurance scheme:**
**X** province/region

13. **Type of basic health care services covered by the scheme:**
**X** hospital treatment: hospitalisation (accommodation and health care) is paid 30,000 CFA Franc; surgery is paid 30,000 CFA Franc
**X** midwife services/ reproductive health care: delivery is paid 30,000 CFA Franc

14. **Method of financing the health insurance:**
**X** members' contributions: yearly premium for a family is 12,000 CFA Franc. Family members are: subscriber and his/her minors.

15. **Members' participation in the management of the scheme:**
**X** democratic administration of the scheme by members (general assembly)**:** general assembly, governing body, office and control committee meet regularly. The mutual does not have an office and is managed by 9 temporary volunteers.

16. **External technical assistance**
Information not available

17. **Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

Mpouakone is a mutual that carries out two types of activities: health insurance with an annual premium of 12,000 CFA Franc and a tontine with a non-fixed amount of contribution. Many women subscribe to the tontine but not to health insurance because they cannot afford to pay 12,000 CFA Franc.

The mutual encounters difficulties in keeping documents of its accounts. Nevertheless those in charge show receptiveness and dynamism to improve themselves for the benefit of the mutual association. They have expressed the desire to undergo management training on health insurance.

**-Any bibliographical and written references:**

Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

# VI. Mupehoproma

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** BP 948 BAFOUSSAM
   ***Telephone:*** +237-44 29 06

3. **Contact person:**
   David DJIALA, President
   Luc OUANJI, Manager

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society: professional community

5. **Year (and month) when the scheme was (formally) set up:** May 1995

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** May 1995

7. **Total number of male/ female members of the scheme:** 101

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 1,007 (Target population: all medical charity personnel of evangelical church in Cameroon, with 5 hospitals on all territories)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** urban area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** national

13. **Type of basic health care services covered by the scheme:**
    **X** hospital treatment: hospitalisation is paid 5,000 CFA Franc in lump-sum.

14. **Method of financing the health insurance:**
    **X** members' contributions: membership fee is 1,000 CFA Franc; annual premium is variable, and is around 12,000 CFA Franc for a family. Family members are: the subscriber, a spouse, the children and direct ascendants.

15. **Members' participation in the management of the scheme:**

**X** democratic administration of the scheme by members (general assembly)**:** general assembly, governing body, office and control committee meet regularly. The mutual has an office and is managed by one full-time employee and 11 temporary volunteers.

**16. External technical assistance**
Information not available

**17. Others (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
This mutual offers other benefits apart from health insurance, like pension, canteen etc. Since the health coverage is relatively small, these extra benefits attract the attention of potential subscribers and helps in recruiting new subscriptions.

On the side of management, the documents of the accounts are not up-to-date, thus contributing to the loss of trust and confidence of members on the management of the mutual.

**-Any bibliographical and written references:**
Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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# VII. Mutuelle Famille Babouantou de Yaoundé or Caisse de Solidarité Babouantou de Yaounde

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**
***Address:*** s/c BP 12 196 YAOUNDE
***Telephone:*** +237-22 23 29
***Fax:*** +237-22 23 30

**3. Contact person:**
Jean Christophe TCHOUATIEU, President
Salomon TCHADIEU, Manager

**4. Type of organization responsible for the HMIS:**
**X** mutual benefit society: Traditional type

**5. Year (and month) when the scheme was (formally) set up:** October 1990

**6. Year (and month) when the scheme began to deliver the first benefits to beneficiaries:**
October 1990

**7. Total number of male/ female members of the scheme:** 250

**8. Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 1,500 (Target population: all Babouantou nationals living in Yaoundé)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
Information not available

11. **Place of residence for the majority of members:**
**X** urban area

12. **Geographical area covered by the health micro-insurance scheme:**
**X** commune/village

13. **Type of basic health care services covered by the scheme:**
**X** hospital treatment: hospitalisation (accommodation and health care) is paid 20,000 CFA Franc; surgery is paid 20,000 CFA Franc.

14. **Method of financing the health insurance:**
**X** members' contributions: membership fee is 1,000 CFA Franc for men only; yearly premium for an individual is 5,000 CFA Franc (2,000 CFA Franc for adult students). Only minors are covered by their parents' premium; the spouse(s) would have to pay a premium.

15. **Members' participation in the management of the scheme:**
**X** democratic administration of the scheme by members (general assembly)

16. **External technical assistance**
Information not available

17. **Others (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
This mutual is run by a stringent management. For a few years, it has experienced a reduction of subscribers, and this is attributed to a reduction of purchasing power of the people.

The managers wish to increase the premiums to meet the increasing costs of health care, but the living standard of insured members does not allow this move.

**-Any bibliographical and written references:**
Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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# VIII. NSO-NGON

1. **Name of the organization responsible for the HMIS or its owner**

**(if the ownership is legally defined):**

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** BP 151 Yaounde, Cameroon

3. **Contact person:**
   Martin ATEBA, President

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society: social community

5. **Year (and month) when the scheme was (formally) set up:** 1976

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 1976

7. **Total number of male/ female members of the scheme:** 52

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** Not evaluated (around 250) (Target population: everybody who is interested)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** rural area
    **X** urban area
    **X** urban surroundings

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** national

13. **Type of basic health care services covered by the scheme:**
    **X** hospital treatment: hospitalisation (accommodation and health care) is paid 30,000 CFA Franc; major surgery is paid 30,000 CFA Franc
    **X** midwife services/ reproductive health care: delivery is paid 10,000 CFA Franc
    Note: Benefits are paid in lump-sum

14. **Method of financing the health insurance:**
    **X** members' contributions: membership fee is 2,000 CFA Franc; annual premium for a family is 30,000 CFA Franc. Family members are: the subscriber, the spouse(s), the children and direct ascendants.
    **X** others: interests from loans granted by the mutual to its members

15. **Members' participation in the management of the scheme:**

**X** democratic administration of the scheme by members (general assembly): general assembly and office meet regularly. The mutual does not have control committee and neither an office. It is managed by 8 temporary volunteers.

**16. External technical assistance**
Information not available

**17. Others (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
The mutual has benefitted from smooth interpersonal relations among its members and cooperation they extend by paying their premiums and participating in meetings. In addition to its health insurance, the mutual grants loans to its members. It is in this loans programme that the mutual has experienced difficulties in recovering the amounts due.

**-Any bibliographical and written references:**
Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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# IX. POOMA (Yaoundé)

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**
***Address:*** s/c Catherine DJITE, CHU de YAOUNDE
***Telephone:*** +237-23 61 86

**3. Contact person:**
Catherine DJITE, President
Madeleine MUMENIYI, Manager

**4. Type of organization responsible for the HMIS:**
**X** mutual benefit society: traditional type

**5. Year (and month) when the scheme was (formally) set up:** September 1987

**6. Year (and month) when the scheme began to deliver the first benefits to beneficiaries:**
September 1987

**7. Total number of male/ female members of the scheme:** 50

**8. Total number of members in the organization that has set up the scheme:**

**9. Total number of current male/ female beneficiaries of the scheme:** 200 (Target population: all women living in Yaoundé who are Babouantou natives)

**10. Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
Information not available

**11. Place of residence for the majority of members:**
- **X** rural area
- **X** urban area
- **X** urban surroundings

**12. Geographical area covered by the health micro-insurance scheme:**
- **X** province/region

**13. Type of basic health care services covered by the scheme:**
- **X** hospital treatment: hospitalisation is paid a lump-sum of 30,000 CFA Franc
- **X** midwife services/ reproductive health care: delivery is paid in lump-sum of 26,000 CFA Franc

**14. Method of financing the health insurance:**
- **X** members' contributions: membership fee is 45,000 CFA Franc; annual premium for a family is 25,000 CFA Franc. Family members are: the subscriber, a spouse, the children and direct ascendants.
- **X** others: interests from loans granted by the mutual to its members

**15. Members' participation in the management of the scheme:**
- **X** democratic administration of the scheme by members (general assembly): there is a general assembly each year; the governing body, office and control committee meet according to their needs. The mutual does not have an office. It is managed by 12 temporary volunteers.

**16. External technical assistance**
Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
This mutual benefits from the goodwill of its managers and the prevailing spirit of solidarity among its members. Nevertheless, it suffers from inadequate bookkeeping and management. It has also encountered difficulties in collecting premiums. People in charge of the mutual wish to undergo training in order to manage awareness-raising campaign within the group.

**-Any bibliographical and written references:**
Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

# Ghana

I. Dagaaba Association in Duayaw Nkwanta, Brong Ahafo region
II. Nkoranza Community Financing Health Insurance Scheme
III. The Proposed District Health Insurance Schemes (DHIS)
IV. The Proposed Motauk Lafia Health Insurance Scheme
V. West Gonja Hospital Community Financing Health Insurance Scheme

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## I. Dagaaba Association in Duayaw Nkwanta, Brong Ahafo region

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Dagaaba Association in Duayaw Nkwanta

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**

3. **Contact person:**

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society: it is a traditional social network or ethnic-based organization for those migrants originate from the Upper West Region of Ghana.

5. **Year (and month) when the scheme was (formally) set up:**

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:**

7. **Total number of male/female members of the scheme:** 82 (as of Nov. 1997)

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 160 (Target population: all Dagaaba people living in Duayaw-Nkwanta and its surrounding villages, who are 18 years and above. Dagaaba women who marry to members of other ethnic groups can be members, but their husband cannot)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** urban area
    **X** urban surroundings

**12. Geographical area covered by the health micro-insurance scheme:**

**X** commune/village

**13. Type of basic health care services covered by the scheme:**

**X** hospital treatment: For one day or longer hospitalisation, a member receives 5,000 cedis as financial support. In addition, all members are required to visit the sick member as a sign for solidarity.

Note: the association also offers death and survival benefits and assistance to victims of natural disaster.

Death and survival benefits:

- The association buys the coffin but members are asked for additional contributions to pay for the cost.
- It provides initial assistance of not more than 20,000 cedis (US$8.89) to the bereaved family for burial and funeral expenses.
- The surviving spouse of the deceased member gets a cash donation of 10,000 cedis.
- In the case of the death of a member's child, a cash donation of 5,000 cedis is paid to the member.
- In the event of the death of a member's spouse, a donation of 10,000 cedis will be paid to that member.

**14. Method of financing the health insurance:**

**X** members' contributions: 2,000 (US$0.89) cedis non-refundable membership registration fee and a monthly contribution of 500 cedis.

**15. Members' participation in the management of the scheme:**

**X** democratic administration of the scheme by members (general assembly): meetings of all members are held every first Sunday of the month. An annual general meeting is held in December, during which financial reports are presented and elections for executive officers are held after every two years. The executive committee also meets frequently.

**16. External technical assistance**

Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

The contribution of this small association to its members' health is considered to be negligible, if only the 5,000 cedis health benefits is taken into account. The cost of in-patient care at a district hospital is far too high compare to the illness benefits a member may receive. Data from the Nkoranza district hospital, which reflects well the cost of health care with a district hospital at Duayaw-Nkwanta, shows that deposit for a minor operation cost 40,000 cedis (about US$18.00). For a major operation, deposit could cost between 80,000 to 100,000 cedis. Even for a common malaria or a normal delivery, a deposit of 30,000 cedis is required.

However, informal arrangements could be made, like loans are being provided to members with real difficulty in raising the required deposit for in-patient care. This has an even stronger and direct impact to the equity of health care access for some of the indigent

members within the association. In addition, the social and welfare services offered contribute to the alleviation of social deprivation of these members.

Weakness:

- Irregular monthly contribution
- No written contracts with medical service providers, hence the association could not ensure greater efficiency from the service providers.

**-Any bibliographical and written references:**

Atim, C. (1998) "Non-profit mutual health organizations (MHOs) in West and central Africa: Ghana Case Studies", *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* A copy of this case study can be obtained from STEP. Please contact Ms. Victoria Giroud-Castiella. Tel: +41-22-799 6072. Fax: +41-22-799 6644. Email: giroud@ilo.org

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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## II. Nkoranza Community Financing Health Insurance Scheme

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Nkoranza Hospital

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**

3. **Contact person:** Simon Unezumeh (Officer in charge of Nkoranza Insurance Scheme), William Sabi (Assistant Hospital Administrator), Samuel Adu-Poku and James Bonah (Coordinator and deputy coordinator respectively of Nkoranza insurance scheme)

4. **Type of organization responsible for the HMIS:**
   **X** non-profit health care provider: this is a missionary hospital

5. **Year (and month) when the scheme was (formally) set up:** October 1991

7. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 1st February 1992

7. **Total number of male/female members of the scheme:** 27,031 (1994); 36,609 (1993); 31,773 (1992);

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 27,031 (1994); 36,609 (1993); 31,773 (1992); (Target population: estimated to be 117,500)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** rural area

**12. Geographical area covered by the health micro-insurance scheme:**

**X** department: district

**13. Type of basic health care services covered by the scheme:**

**X** hospital treatment: only in-patient treatment, excluding detainees (those who stay less than 24 hours in the hospital)

**14. Method of financing the health insurance:**

**X** members' contributions: family membership only. For new member, it is 1,200 cedis (US$1.40) in 1994, Increased from 700 cedis from the previous year. For renewal, it is 1,000 cedis (US$1.20) in 1994 and 550 cedis in the previous year.

**X** non-state subsidies from development agencies, donors etc. Memisa, the major donor to the insurance scheme, guaranteed to bear all financial deficits made in the first three year (1992-1994) of the insurance scheme.

**15. Members' participation in the management of the scheme:**

Information not available

**16. External technical assistance**

**X** receives regular external technical assistance:

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

The Catholic Diocesan Health Committee and the senior medical officer-in-charge of Nkoranza district Hospital launched the Nkoranza insurance scheme in 1992. It was explicitly intended to be a pilot project and a blue print for all other Catholic hospitals in the country to draw useful lessons from before establishing their own future community health financing scheme.

It receives financial and technical assistance from Memisa, an international church-related NGO in Holland.

Weaknesses:

- non or low participatory from the local people
- need to improve its marketing
- need quality control mechanisms
- lack of preventive/ health promotion services
- without independence from the medical service provider
- lack of efforts invested in making the scheme as financially sustainable as possible in the first three years of operation.
- need to enhance internal control system
- bookkeeping still need improvement, especially in maintaining an updated and accurate recording and filing system.
- not all family members are registerd, hence limiting risk-sharing and giving rise to adverse selection
- overuse of this district referral hospital on minor illnesses. It is necessary to develop a referral procedure with other local health centres and health posts.

Strengths and good practice:

- adopts family membership registration instead of individual registration
- it has good identification method of insured persons seeking admission to wards
- regular evaluations are carried out on the performance of the insurance scheme.
- adequate modifications are adopted promptly as recommended by evaluations.
- enhanced efficiency of workers. Zonal co-ordinator and field workers are now replaced by 21 field officers paid by contract and given specific targets to achieve, hence can potentially reduce a layer of management work.

Disadvantages to insurance policy holders/beneficiaries:

- lack of negotiating power
- dependence on the medical service provider

**-Any bibliographical and written references:**

Somkang, E., Akanzinge, P., Apau, T. and Dr. Moens, F.(1994) *Nkoranza Health Insurance Evaluation Report*, Diocese of Sunyani, Ghana and Memisa Medicus Mundi, The Netherland.

Atim, C. (1998) "Non-profit mutual health organizations (MHOs) in West and central Africa: Ghana Case Studies", *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* A copy of this case study can be obtained from STEP. Please contact Ms. Victoria Giroud-Castiella. Tel: +41-22-799 6072. Fax: +41-22-799 6644. Email: giroud@ilo.org

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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# III. The Proposed District Health Insurance Schemes (DHIS)

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** District Health Insurance Association (DHIA)

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**

3. **Contact person:**

4. **Type of organization responsible for the HMIS:**
   **X** others: a decentralised national body

5. **Year (and month) when the scheme was (formally) set up:**

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:**

7. **Total number of male/female members of the scheme:**

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** (Target population: members of various informal sector occupational associations and co-operatives, the number varies from district to district)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

**11. Place of residence for the majority of members:**

**X** rural area

**X** urban area

**X** urban surroundings

**12. Geographical area covered by the health micro-insurance scheme:**

**X** province/region

**13. Type of basic health care services covered by the scheme:**

**X** out-patient care: comprehensive out-patient service are currently provided by health centres and hospitals in the district.

**X** hospital treatment: comprehensive in-patient service are currently provided by health centres and hospitals in the district.

**X** medical evacuations: there is a fixed rate to cover transportation expenses for members referred for treatment outside the district, but such referral treatment will not be paid for by the scheme.

**14. Method of financing the health insurance:**

**X** members' contributions: individual membership with annual premium

**X** state contribution: there will be initial government support in acquisition of essential inputs such as office equipment.

**X** non-state subsidies from development agencies, donors etc.: a donor will extend initial support to the scheme

Note: Premiums rates in each district may vary, depending on the cost of health services, utilisation rate and annual inflation. The scheme should eventually be financially self-sufficient at the district level.

**15. Members' participation in the management of the scheme:**

**X** members' involvement in the organization responsible for the administration of the health micro-insurance scheme

**16. External technical assistance**

**X** receives regular external technical assistance: the proposed DHIS is backed by DANIDA, the Danish co-operation agency.

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

The proposed District Health Insurance Scheme is a complement to the proposed national health insurance scheme for employees in the formal sector. The DHIS seeks to "formulate and implement a health insurance policy for the 'informal' sector". Hence, DANIDA has begun some pilot studies to examine its feasibility. The pilot studies will initially be carried out in four of the ten regions, namely Eastern, where the national health insurance scheme is also being tested, Volta, Greater Accra and Upper West regions. One district will be selected in each region for the pilot study.

The objectives of the DHIS:

- To achieve universal coverage for primary health care

- To make health care more economically and geographically accessible by inhabitants of the districts
- To ensure an acceptable minimum health care service at the PHC level
- To generate additional resources for health care.

An interesting feature of the proposed DHIS is to give discount to members who have not claimed benefits within a given year. This is designed to avoid abuse of the system and to encourage renewal of membership among healthy members.

Possible drawbacks:

- Lack of managerial and technical experties in the country for health insurance management
- The important role held by the district assemblies in fund-raising and policy-making might be used by politicians for their own goals
- There is a danger of limited risk pooling by adopting individual membership as against family membership

**-Any bibliographical and written references:**

Atim, C. (1998) "Non-profit mutual health organizations (MHOs) in West and central Africa: Ghana Case Studies", *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM*. A copy of this case study can be obtained from STEP. Please contact Ms. Victoria Giroud-Castiella. Tel: +41-22-799 6072. Fax: +41-22-799 6644. Email: giroud@ilo.org

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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# IV. The Proposed Motauk Lafia Health Insurance Scheme

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   **Address:** Bunkpurugu-Yunyoo, Ghana

3. **Contact person:**

4. **Type of organization responsible for the HMIS:**
   **X** other community organization

5. **Year (and month) when the scheme was (formally) set up:**

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:**

7. **Total number of male/female members of the scheme:**

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** (Target population: 85,000)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**

Information not available

**11. Place of residence for the majority of members:**
**X** rural area

**12. Geographical area covered by the health micro-insurance scheme:**
**X** department: Bunpkurugu-Yunyoo constituency

**13. Type of basic health care services covered by the scheme:**
**X** out-patient care
**X** hospital treatment
Note: same as the proposed DHIS benefits package.

**14. Method of financing the health insurance:**
**X** members' contributions

**15. Members' participation in the management of the scheme:**
Information not available

**16. External technical assistance**
Information not available

**17. Others (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
The proposed Motauk Lafia Health Insurance Scheme for Bunpkurugu-Yunyoo complements the proposed national health insurance scheme for the formal sector employees.

Bunpkurugu-Yunyoo is a rural savannah constituency in the East Mamprusi District. Farming is concentrated during the three-month rainy season. There is little non-farm employment opportunities and this area has considerable poverty, malnutrition and poor health.

**-Any bibliographical and written references:**
Atim, C. (1998) "Non-profit mutual health organizations (MHOs) in West and central Africa: Ghana Case Studies", *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* A copy of this case study can be obtained from STEP. Please contact Ms. Victoria Giroud-Castiella. Tel: +41-22-799 6072. Fax: +41-22-799 6644. Email: giroud@ilo.org

**-Names of persons and/or organizations that can provide additional information about the scheme:**
Note: Ghanian government's continuous support for community-financed health insurance scheme can be shown from its 1999 budget announcement regarding the health sector. It stated that "to increase the financial base of the health sector, risk-sharing schemes will be promoted and expanded beyond the regular health insurance to include various forms of community-based financing schemes".

# V. West Gonja Hospital Community Financing Health Insurance Scheme

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** West Gonja Hospital

2. **Address of the HMIS Head Office (or contact address of the responsible organization): Address:** West Gonja Hospital, Damongo, Ghana

3. **Contact person:** John Kipu Kaara (Coordinator of West Gonja Insurance Scheme), Stefan Marx (Manager of West Gonja Insurance Scheme), Rev. Dr. Veronica (Medical Officer in charge of the West Gonja Hospital)

4. **Type of organization responsible for the HMIS:**
   **X** non-profit health care provider: the hospital belongs to SSpS Sisters of the Roman Catholic Church

5. **Year (and month) when the scheme was (formally) set up:** October 1995

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** January 1996

7. **Total number of male/female members of the scheme:** 13,360 (as of 12 Nov. 1997), rose from 4,890 from the end of Sept. 1996.

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 13,360 (as of 12 Nov. 1997) (Target population is estimated to be 120,000, the total population of the district in 95/96)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    **X** more than 50%: the vast majority of the population is subsistence farmers. There is a significant minority are commercial farmers, civil servants and other salaried workers.

11. **Place of residence for the majority of members:**
    **X** rural area: It is a rural district situates in one of the poorest regions of Ghana

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** department: district

13. **Type of basic health care services covered by the scheme:**
    **X** hospital treatment: "catastrophic illness"
    Note: there is a waiting period of three months

14. **Method of financing the health insurance:**
    **X** members' contributions:
    - New membership: 4,000 cedis (about US$1.70) (as of 1st October 1997), increased from 2,500 cedis in the previous year.

- Renewals is 3,500 cedis (about US$1.50) (as of 1st October 1997), increased from 2,000 cedis the previous year. A renewing member has up to 8 days from the expiry date of the membership to re-register to avoid the one-month waiting period penalty.
- The insurance offers individual membership and optional family membership.

**X** non-state subsidies from development agencies, donors etc.: a German NGO funds a so-called "charity registration", providing free membership to indigents who are identified by the community and also providing subsidies to the membership fees of secondary school students. Misereor, the main donor of the insurance scheme, provided a loan of DM 50,000 (over 52 million cedis) for the start-up phase of the scheme. In addition, Misereor guarantees an annual subsidy to the scheme for the first three years of operation, which breaks down as follows: DM15,000 each for 1996 and 1997 and DM20,000 for 1998.

**X** others: some German NGOs connected to the insurance scheme donated a new office block to the hospital. In addition, membership cards are printed in Germany by a donor for free. There are also donations of equipment of various kinds, hand-outs are printed for free and so on.

**15. Members' participation in the management of the scheme:**
Information not available

**16. External technical assistance**

**X** receives punctual external technical assistance as required: the project manager and co-ordinator received capacity-building courses in Germany.

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

The health insurance scheme is in part a response to accumulating bad debts from non-payment by indigent patients, which poses a threat to the financial standing of the hospital. Another reason for the establishment is to allow poor patients to seek medical treatment promptly. It is common for patients who know that they can't afford the user fees delay seeking medical help, and only go to hospital as a last resort. The seriousness of their illness then directly contributes to even higher medical bills.

The insurance scheme also contributes to the equity of health care access in the poverty-stricken rural area of Savannah, Ghana

Strength and improvements achieved:

- the hospital enjoys very good reputation for quality service throughout the entire northern part of the country. In the past, there have been patients came all the way from Accra, the capital city for treatment.
- the gradual expansion of geographical coverage of the district, from 10 km radius in the first year to 20km in the second year and 50 km in the third year, allows administrative capacity of the insurance scheme to be consolidated
- bad debt provision declined drastically from 4,411,700 cedis (US$1,960) at the end of 1995 to just 12,000 cedis (US$5.33) at the end of 1996.
- low premium rates. Interviews with agricultural settlements around Damongo, especially with those non-insured persons, showed that the level of the premium posed no serious barrier to insurance membership. The annual premium for a new member is worth 2.4 days of the national daily minimum wage rate.

- the insurance's in-patient payment to the hospital as a percentage of the total hospital in-patient revenue increased from 13% in Jan. '97 to 26% in June '97, providing a more stable and constant source of revenue for the hospital.
- hospital pharmacist and users in the community both found drug availability has improved since the scheme was started.
- some financial reserves have been accumulated from unused subsidy of Misereor, and the insurance management team plans to use it to finance an income generating business.
- regular monitoring and evaluation exercises are planned

Weakness:

- none or low participation from the local people did not help to build solidarity and social control on the use of medical services. This could be part of the reason for low renewal rate in the second year of operation of the scheme.
- evidence of significant adverse selection and moral hazard
- poor marketing strategies
- absence of quality and cost control mechanisms
- lack of preventive or health promotion services
- without independence from the medical service provider
- little attention is given to raise the quality of health care offered by the hospital while keeping down the costs.
- absence of set rules on refund for generic or essential drugs.
- little referral co-ordination with the surrounding government managed health posts, as a result, this district referral hospital is used even for minor illnesses.

Disadvantages to insurance policy holders/beneficiaries:

- lack of negotiating power
- without independence from the medical service provider

General difficulties faced by the insurance scheme:

This district is considered the largest in the country, with very poor road construction. During rainy season, many villages are cut off from Damongo, the district capital, where the hospital is situated. There is no regular means of transport linking Damongo and outlying villages. Thus the hospital ambulance and other vehicles play a crucial role in transporting patients to and from the hospital. The insurance organisers rely on their own VW carrier van to conduct campaigns and educational programme, health insurance awareness and registration activities.

### -Any bibliographical and written references:

Atim, C. (1998) "Non-profit mutual health organizations (MHOs) in West and central Africa: Ghana Case Studies", *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* A copy of this case study can be obtained from STEP. Please contact Ms. Victoria Giroud-Castiella. Tel: +41-22-799 6072. Fax: +41-22-799 6644. Email: giroud@ilo.org

**-Names of persons and/or organizations that can provide additional information about the scheme:**

# Kenya

I. Chogoria Hospital Health Insurance Scheme

II. Tumutumu Hospital's Community-based Health Insurance, Nyeri and Kirinyaga districts

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## I. Chogoria Hospital Health Insurance Scheme

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** PCEA Chogoria hospital, Kenya

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**
**Address:** P.O.Box 35, Chogoria, Kenya
**Telephone:** +254-166-22620
**Email:** chogoria@africaonline.co.ke
**Fax:** +254-166-22122

**3. Contact person:** Judith E. Brown, who recently replaced Dr. Gordon McFarlane, Medical Superintendent

**4. Type of organization responsible for the HMIS:**
**X** non-profit health care provider: this missionary hospital is owned by Presbyterian Church in East Africa (PCEA).

**5. Year (and month) when the scheme was (formally) set up:** 1991

**6. Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 1991

**7. Total number of male/female members of the scheme:** 241 (1998)

**8. Total number of members in the organization that has set up the scheme:**

**9. Total number of current male/ female beneficiaries of the scheme:** 241 (1998)

**10. Proportion of beneficiaries a) excluded from other social security systems or b) with income below the poverty line:**
Information not available

**11. Place of residence for the majority of members:**
**X** rural area

**12. Geographical area covered by the health micro-insurance scheme:**
**X** commune/village

**13. Type of basic health care services covered by the scheme:**

**X** out-patient care

**X** hospital treatment

Note: Health care services that are not covered by the health insurance scheme

- Diseases that were diagnosed prior to joining the scheme or within the waiting period
- Coverage is only up to 64 years old
- AIDS treatment is provided up to a maximum of Sh.36.00 per year
- Psychiatric illness treatment is limited to Sh.68.00 per year
- Expenses that are related to normal or abnormal pregnancy
- Spectacles, eye and ear tests, and hearing aids
- Self-inflicted injuries
- Birth defects and cosmetic surgery
- Dental treatments
- Medical examinations
- Procedures carried out for non-medical reasons like circumcision.

Note: the health care service coverage is decided by the doctors on the basis of public health criteria.

**14. Method of financing the health insurance:**

**X** members' contributions: US$14.40 per person per year (1998)

**X** other: co-payment of US$0.36 for an outpatient consultation at a health centre and US$0.55 for a visit to hospital's outpatient department.

Note: Waiting period for an individual is two months, while for a group is only two weeks

**15. Members' participation in the management of the scheme:**

Information not available

**16. Technical assistance**

Information not available

**17. Other (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

In order to spread the risk over a wider base, members are given attractive premium and a shorter waiting period when they subscribe as a group of 50 individuals.

Co-payments were introduced for outpatient consultations at the health centre and the hospital to rectify the problem of over-consumption of outpatient care (between 1996 and 1997, the consumption of outpatient care rose from 1.71 contacts per person per year to 2.78). It is found that consumption of outpatient care is strongly correlated to the amount of patient's contribution. Experience shows that health insurers (at least in the Sub-Sahara Africa) should be extremely cautious in defining the health care "package". Coverage of outpatient care is considered risky and should always be accompanied by a consultation charge/ co-payment.

Three measures were taken to solve the problem of financial deficit

- Premiums were increased considerably in the period of 1991 to 1998.
- Awareness-raising programmes were conducted both for personnel and for members to explain the running of the insurance system and its limitations.

- By using generic drugs and rationalising treatment and management, health care can be provided at low cost, allowing the insurance scheme to break even.

However, increase financial contribution from the part of members and other measures to reduce the financial deficit have significantly reduced the membership. Membership fell from 7,746 in 1993 to 241 in 1998.

Up to November 1998, the insurance scheme provides coverage to hospital staff members only.

Organization and management models have been developed. The hospital plans to conduct market surveys in order to offer medical care coverage according to the needs of the rural population and understand their difficulties in seeking health care.

Consumption of hospital inpatient care since 1991 is fairly stable and does not appear to be affected by the tendency of over-consumption that exists in outpatient care.

**-Any bibliographical and written references:**

Creese, A. and Bennett, S. (1997) *Rural Risk-Sharing Strategies* in "Innovations in Health Care Financing", a World Bank Discussion Paper No. 365, edited by Schieber, G.J., p.163-182.

Bennett, S., Creese, A. and Monasch, R. (1998*) Health Insurance Schemes for People Outside Formal Sector Employment*, ARA Paper number 16, Division of Analysis, Research and Assessment of World Health Organization.

Debaig, G. (1999) Report on the "Community Based Health Insurance Regional Conference" at Kampala, Uganda, on 9-13 November 1998.

Brown, J.E. (1999) "Chogoria hospital insurance scheme, PCEA Chogoria hospital", an unpublished workshop paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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# II. Tumutumu Hospital's Community-based Health Insurance, Nyeri and Kirinyaga districts

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** PCEA Tumutumu Hospital

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   **Address:** PCEA Tumutumu Hospital, Private Bag, Karatina, Kenya
   **Telephone:** +254-171-72026/ 33
   **Email:** tumutumu@africaonline.co.ke
   **Fax:** +254-171-72656

3. **Contact person:** Dr. Elizabeth Bevan, Medical Officer in charge (until February 2000)

4. **Type of organization responsible for the HMIS:**
   **X** non-profit health care provider: this hospital is owned by Presbyterian Church in East Africa

5. **Year (and month) when the scheme was (formally) set up:** beginning of 2000

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** beginning of 2000

7. **Total number of male/female members of the scheme:** unknown

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** unknown (Target population: rural population in the catchment area of Tumutumu Hospital, members of pre-existing mutual aid groups)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** rural area: within the catchment area of Tumutumu Hospital

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village

13. **Type of basic health care services covered by the scheme:**
    **X** hospital treatment: including surgery
    **X** midwife services/ reproductive health care
    **X** medicines
    **X** other: including laboratory tests

14. **Method of financing the health insurance:**
    **X** members' contributions: Plan1 is US$40 for a family of 6 per year; Plan2 is US$20 for a family of 6 per year. Co-payment of US$17 for hospitalisation under Plan 1 or US$70 under Plan2.

    Note: Members of mutual aid groups pay their insurance subscription into their individual insurance fund, and each mutual aid group then pays a groups insurance (depends on the number of members) to Tumutumu Hospital for inpatient and other health care services. An individual member will only need to pay a consultation charge (or co-payment) when he/she seeks health care at Tumutumu Hospital. Under Plan1, the co-payment is US$17 and US$70 for Plan 2.

15. **Members' participation in the management of the scheme:**
    **X** democratic administration of the scheme by members (general assembly): It is a self-managed insurance system that belongs to beneficiaries.

**16. Technical assistance**

**X** receives regularly external technical assistance: the insurance scheme receives technical assistance from CIDR (Centre Internationale de Developpement et de Recherche)

**17. Other (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

The objective of this insurance scheme is to offer quality health care service at a price mutual aid groups, and hence its members, can afford. By accepting only group membership and not individual membership, Tumutumu hospital may able to minimise the problem of adverse selection. In addition, insurance members would have to belong to one of the mutual aid groups already. The spirit of solidarity and peer pressure may also help to reduce the problem of moral hazard. Co-payments too are generally being considered to be an effective measure in minimising the latter problem.

A study that was carried out before launching the insurance scheme found local people's perception of the quality of care is paramount. Population in Nyeri expressed a preference for missionary hospitals over government health services. They have more confidence on the quality of care provided by missionary hospitals, in addition to better reception, availability of drugs and personnel.

85% of the individuals interviewed for the study demanded mainly in-patient coverage, which include medical, surgical, maternity etc.. Costs in outpatient care generally do not exceed US$3.50 per consultation (including drugs), hence only a small percentage of people demands for outpatient coverage.

In Nyeri, financial difficulties is often related to the need of paying school fees. Solidarity and mutual aid between the locals are strong. There are already mutual aid groups called Harambee that allow risk sharing among members and reduce the financial burden of illness in affected households. As a result, one can deduce that social acceptability of an insurance scheme here is higher.

**-Any bibliographical and written references:**

Debaig, G. (1999) Report on the "Community Based Health Insurance Regional Conference" at Kampala, Uganda, on 9-13 November 1998.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

Mr. Guillaume Debaig, CIDR, P1, 60350 Autrecmes, France

Email: cidr@compuserve.com

Tel: +33-344-92 71 40

Fax: +33-344-42 94 52

Ms. E. Yard, CIDR, P.O.Box 149, Luweero, Uganda

Fax: +256-41-610 132

# Mali

I. Centre de Santé MUTEC (Mutuelle des travailleurs de l'Education et de la Culture)

II. La mutuelle de santé du quartier de l'hippodrome à Bamako

III. MEUMA (Mutuelle des Etudiants et Universitaires du Mali)

IV. MUTAM (Mutuelle des artisans du Mali)

V. MUTAS (Mutuelle des Travailleurs de l'Action Sociale et de la Santé)

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## I. Centre de Santé MUTEC

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:***Quartier du Fleuve, BP 2707 BAMAKO
   ***Telephone:*** +223-22 95 08

3. **Contact person:**
   Babassa DJIKENE, Président de la MUTEC
   Ismaïla CAMARA, Directeur du centre de santé MUTEC

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up:** February 1990

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** February 1990

7. **Total number of male/ female members of the scheme:** 833

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** Around 8,000 (Target population: all workers of l'Education Nationale and all interested people)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** urban area

**12. Geographical area covered by the health micro-insurance scheme:**

**X** national

**13. Type of basic health care services covered by the scheme:**

**X** outpatient care: general practitioner's consultations (subscriber:200 FCFA, non-subscriber:1,000 FCFA); children (0 -12 years old) consultation (subscriber:0, non-subscriber:300 FCFA), nursing care (subscriber:100, non-subscriber:300)

**X** hospital treatment: without overnight stay (subscriber:2,500 FCFA, non-subscriber:6,000), drip/IV (subscriber:0, non-subscriber:750)

**X** midwife services/ reproductive health care: gynaecological consultation (subscriber:2,000 FCFA, non-subscriber:5,000 FCFA), delivery (subscriber:2,000 FCFA, non-subscriber:10,000 FCFA), maternal and infant health record (subscriber:500 FCFA, non-subscriber:500), ultrasound scanning (subscriber:2,500 FCFA, non-subscriber:6,000 FCFA)

**X** medicines

**X** medical evacuations: ambulance rental (subscriber:1,250 CFA, non-subscriber:3,000 FCFA)

**X** others: circumcision (subscriber:1,500 FCFA, non-subscriber:3,000 FCFA), medical test, dental treatment, radiology (had an agreed tariff with a radiology cabinet)

**14. Method of financing the health insurance:**

**X** members' contributions: annual premium of 12,000 FCFA per family for MUTEC subscriber; annual permium of 15,000 FCFA per family for personnel of l'Education Nationale but not MUTEC subscriber; annual premium of 18,000 FCFA per family for whoever applies. Family members are: the subscriber, the spouse(s), the children and direct ascendants. Premium payments are automatically withdrawn or pay directly by subscriber.

**X** others: payments from medical treatment/consultation and medicines by the patients

**15. Members' participation in the management of the scheme:**

**X** democratic administration of the scheme by members (general assembly): General assembly, the governing body, the control committee meet frequently. The health centre is managed by a paid director.

**16. External technical assistance**

Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

This mutual health centre is relatively well managed and its accounts are well maintain. It offers quality health services at reasonable prices. However, the centre experiences difficulties in collecting premiums from members and in following up late payments.

For several years, it has become increasingly clear who are the clients of MUTEC centre. Today, the majority of the consultations are made by non-insured members. The development of CSCOM in different areas of Bamako encourages people to seek health

services near to their home and it appears that the MUTEC centre is gradually transforming itself into a referral centre of CSCOM.

**-Any bibliographical and written references:**
Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**
For more information, please go to http://www.concertation.org

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## II. La mutuelle de santé du quartier de l'hippodrome à Bamako

It is a health insurance scheme initiated by a private health service provider which covers 100% of the consultation cost, nursing care, medicines, laboratory and technical analysis, in-patient treatment, surgery and deliveries. Insured members play no role in the management of the insurance scheme.

All the health services offered at the mutual health centre can equally be accessed by non-insured members, by paying the full cost.

**Reference:**

Evrard, D. (1998) *Contribution actuelle et potentielle des mutuelles dans la prise en charge des soins de santé au Mali: Etudes de cas,* Alliance Nationale des Mutualité Chrétiennes (ANMC) de Belgique Service coopération internationale. A copy of this case study can be obtained from STEP. Please contact Ms. Victoria Giroud-Castiella. Tel: +41-22-799 6072. Fax: +41-22-799 6644. Email: giroud@ilo.org

For more information, please go to http://www.concertation.org

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## III. MEUMA (Mutuelle des Etudiants et Universitaires du Mali) (Mutual of students and University of Mali)

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** s/c de l'ENSUP/FLASH, BP E 414 - BAMAKO
   ***Telephone:*** +223-22 34 63 s/c d'Alidji BORE

3. **Contact person:**
   Abdoulaye BORE, President

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up:** November 1993

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** Not yet started

7. **Total number of male/ female members of the scheme:** 30

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 30 (Target population: students)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** urban area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** national

13. **Type of basic health care services covered by the scheme:**
    **X** preventive care and health promotion
    **X** outpatient care
    **X** hospital treatment
    **X** midwife services/ reproductive health care
    **X** medicines
    **X** medical evacuations
    **X** others: The mutual hopes to cover 50% of all health claims.

14. **Method of financing the health insurance:**
    **X** members' contributions: 2,500 CFA Franc membership fee, and monthly premium of 1,000 CFA Franc per subscriber, 250 CFA Franc per child, 1,000 CFA Franc per spouse.
    **X** others: Help from DNAS (Department of National Health Association?) and Ministry of Higher Education (printing charges of subscribers' cards and public notice.

15. **Members' participation in the management of the scheme:**
    **X** democratic administration of the scheme by members (general assembly): General assembly, the governing body meet frequently. The mutual is managed by 7 temporary volunteers.

16. **External technical assistance**
    Information not available

17. **Others (if applicable):**
    **-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
    La mutuelle des étudiants (The Student Mutual) benefits from the strong solidarity between members and strong motivation of its managers. However, the mutual is experiencing difficulties in organization. It does not have an office, neither material and finance. It hopes

to establish a health insurance system but it recognises the difficulties in recruiting new subscribers.

In essence, a student mutual is a transitional mutual. It is difficult to recruit the very first batch of subscribers because during the planning period, subscribers are not yet entitled to any benefits.

Before starting a health insurance scheme, MEUMA would have to offer profitable services to attract new subscribers (e.g. buying a photocopy machine to service students' demand for photocopying and generate income at the same time)

**-Any bibliographical and written references:**
Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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# IV. MUTAM (Mutuelle des artisans du Mali)

This mutual started in October 1997, providing health service coverage to self-employed craftmen at MUTEC's Health Centre. It has approximately 300 members in 1998. It is the first mutual in Mali that is specially for informal sector workers.

**Reference:**

Evrard, D. (1998) *Contribution actuelle et potentielle des mutuelles dans la prise en charge des soins de santé au Mali: Etudes de cas,* Alliance Nationale des Mutualité Chrétiennes (ANMC) de Belgique Service coopération internationale. A copy of this case study can be obtained from STEP. Please contact Ms. Victoria Giroud-Castiella. Tel: +41-22-799 6072. Fax: +41-22-799 6644. Email: giroud@ilo.org

For more information, please go to http://www.concertation.org

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# V. MUTAS (Mutuelle des Travailleurs de l'Action Sociale et de la Santé) (Social and Health Workers' Mutual)

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** s/c de la Direction Nationale de l'Action Sociale
   ***Telephone:*** +223-22 42 32

3. **Contact person:**
   **Name:** Mohamed TOURE
   **Address:**
   **Position:** President

4. **Type of organization responsible for the HMIS:**

**X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up:** June 1995

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** Not yet started

7. **Total number of male/ female members of the scheme:** Around 800

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** Not known (Target population: all workers in the public and private health sector; all social workers; other health and social workers in secondment, available or on mission; health and social pensioners)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** rural area
    **X** urban area
    **X** urban surroundings

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** national

13. **Type of basic health care services covered by the scheme:**
    Note: The benefits still have to be defined but the anticipated medical expense reimbursement will cover primary health care, generic medicine, specialist consultation, medical test, radiology, dental treatment and delivery.

14. **Method of financing the health insurance:**
    **X** members' contributions: 5,000 CFA Franc membership fee, and monthly premium of 1,000 CFA Franc per family. Family members are: all those that appear on the family card and designated by the subscriber as an eligible party.
    **X** others: subsidy, donation and loan

15. **Members' participation in the management of the scheme:**
    **X** democratic administration of the scheme by members (general assembly): General assembly, the governing body, the control committee do not meet frequently. To present, only constituent general assembly was called for. The mutual is managed by 2 permanent employees and 8 temporary volunteers. It has offices and material from the ministry.

16. **External technical assistance**
    Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

MUTAS is still in the organising phase. It has started its cereal bank activities in order to attract subscribers before starting to offer pension, life and health insurance.

It benefits from support given by the government but experiences difficulties in recruiting subscribers and collecting premiums. 50% of the premiums are overdue.

The benefits and level of coverage for the health insurance is still to be determined. The motivation of certain administration council members on voluntary help poses some problems.

**-Any bibliographical and written references:**

Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

For more information, please go to http://www.concertation.org

# Senegal

I. Faggaru
II. Diappo
III. Faggu (Mutuelle de santé complémentaire des retraités de l'IPRES)
IV. Fandène
V. Fissel
VI. Gandiol Santé
VII. Goxu Mbaaj
VIII. Koudiadiène
IX. Lalane Diassap
X. Mboro
XI. Médina Gounass
XII. Mont Rolland
XIII. Multi Assistance de l'Education
XIV. Mutuelle de Yoffe or Dimeli Yoff
XV. Mutuelle des Volontaires de l'Education
XVI. Mutuelle Sococim Enterprises
XVII. Ngeye Ngeye
XVIII. Pandhienou Léhar
XIX. Saint Jean Baptiste
XX. Sanghe
XXI. Soppanté
XXII. Thially
XXIII. Thies or Ménagère de Grand Thies

# I. Faggaru

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Mutuelle de santé Faggaru

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** s/c GRAIM , BP:3055 Thiès-Escale ,Senegal
   ***Telephone:*** +221-951-47-69
   ***Fax:*** +221-951-47-69

3. **Contact person:**
   Mame Diarra, President
   Hamidou Cissokho, Administrative secretary

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up:** 11th September,1999

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 10th November,1999

7. **Total number of male/ female members of the scheme:** 135

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 455. 90% of the beneficiaries are women.

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** urban area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village

13. **Type of basic health care services covered by the scheme:**
    **X** hospital treatment: 100% (10 days). Primary health care.
    **X** midwife services/ reproductive health care

14. **Method of financing the health insurance:**
    **X** members' contributions: 1000 CFA Franc membership fee, and monthly premium of 300 CFA Franc per person; family members who may join include the spouse(s), children and direct ascendants.

15. **Members' participation in the management of the scheme:**

**X** democratic administration of the scheme by members (general assembly): General assembly and the governing body meet frequently. The mutual is managed by 3 permanent volunteers . It is now using the office of GRAIM.

**16. External technical assistance**
Information not available

**17. Others (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
The mutual enjoys strong commitments from its administrators and the spirit of solidarity that exists among families. On the other hand, the administrators are lack of training on insurance administration and they experienced difficulties in collecting premiums.

**-Any bibliographical and written references:**
Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:** GRAIM

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# II. Diappo

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**
***Address:*** S/C hopital Saint Jean de Dieu, BP 043A Thiès, Senegal
***Telephone:*** +221-951-19-41

**3. Contact person:**
Dr Charles Diène:President
Bertain Ndione: Treasury

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**4. Type of organization responsible for the HMIS:**
**X** mutual benefit society

**5. Year (and month) when the scheme was (formally) set up:** Dicember1998

**6. Year (and month) when the scheme began to deliver the first benefits to beneficiaries:**
September 1999

**7. Total number of male/ female members of the scheme:** 293

**8. Total number of members in the organization that has set up the scheme:**

**9. Total number of current male/ female beneficiaries of the scheme:** 1800 (Target population: all inhabitants of Thiès excluded from official insurance schemes as well as parents of hospital personnel without health insurance.)

**10. Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
Information not available

**11. Place of residence for the majority of members:**
**X** rural area
**X** urban area

**12. Geographical area covered by the health micro-insurance scheme:**
**X** province/ region

**13. Type of basic health care services covered by the scheme:**
**X** hospital treatment:100% (15 days)

**14. Method of financing the health insurance:**
**X** members' contributions: 2500 CFA Franc membership fee, and monthly premium of 300 CFA Franc per person; family members who may join include the spouse(s), the children and direct ascendants.

**15. Members' participation in the management of the scheme:**
**X** democratic administration of the scheme by members (general assembly): General assembly, the governing body, the control committee meet frequently. The mutual is managed by 1 temporary volunteers. Its office is at l'Hôpital Saint Jean de Dieu.

**16. External technical assistance**
**X** does not receive external technical assistance

**17. Others (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

It is a very young mutual, which explains the weak membership base. Despite of the confidence its members have on the mutual's managers and the proximity of the health service, failures of previous associations in the area and various political orientations may hinder others from joining the mutual.

The mutual planned to insure basic health care services, like consultation, generic medicine and minor surgery at the beginning. In the coming two years, it may enlarge its benefits coverage, depending on members' contribution capacity.

**-Any bibliographical and written references:**
Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:* Hopital Saint Jean de Dieu BP: 043A THIES/Sénégal**
Dr Charles Patrick Diène ,hopital Saint Jean de Dieu

http://www.concertation.org

# III. FAGGU (Mutuelle de santé complémentaire des retraités de l'IPRES)

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Mutuelle de santé complémentaire des retraités de l'IPRES

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** BP 3358, s/c GRAIM, avenue Hôpital St. Jean de Dieu, Thiès, Senegal.
   ***Telephone:*** +221–951 47 69
   ***Fax:*** +221–951 47 69

3. **Contact person:**
   Assane GUEYE, President
   Abdou DIENE, Manager

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up:** 24th October 1994

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 1st January 1995

7. **Total number of male/ female members of the scheme:** 1,019

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** Around 4,000 (Target population: all the retirees of l'IPRES of the Thiès region and the widowed). There is very few women beneficiaries.

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** urban area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** province/region

13. **Type of basic health care services covered by the scheme:**
    **X** hospital treatment: a complementary coverage for l'IPRES (l'IPRES covers 2,000 CFA Franc per day). The mutual has negotiated a discount package which includes hospitalisation (covers 100% of the cost), the health service, emergency visit (covers 30% if the cost), medical test (covers 60% of the cost) and radiology (covers 60% of the cost). L'Hôpital Saint Jean de Dieu agrees to give 50% discount to the insured on other health service.

**14. Method of financing the health insurance:**

**X** members' contributions: The premium for each family is 2,000 CFA Franc every three months. (Family comprises of the subscriber, spouse(s) and the children who are still minors)

**15. Members' participation in the management of the scheme:**

**X** democratic administration of the scheme by members (general assembly): General assembly, the governing body, the control committee meet frequently. The mutual is managed by 4 permanent volunteers, It has an office.

**16. External technical assistance**

Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

This mutual has good organization system, notably the standard of follow-up documention and its control of the beneficiaries. Moreover, the managers share in the spirit of solidarity as shown in their voluntary participation. The number of potential members is very high. However, its members are relatively old, and it has encountered some difficulties in collecting premiums, with more than half delayed in payment.

The next general assembly plans to enlarge the benefits coverage to surgery, specialised and urgent health care.

**-Any bibliographical and written references:**

Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

For more information, please go to http://www.concertation.org

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## IV. Fandène

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** La mutuelle de santé de Fandène, Thiès.

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**

***Address:*** BP 402, Thiès, Senegal

***Telephone:*** --

**3. Contact person:**

Pascal NDIONE, President

André Samba DIOP, Manager

**4. Type of organization responsible for the HMIS:**

**X** mutual benefit society

**5. Year (and month) when the scheme was (formally) set up:** October 1989

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** January 1990

7. **Total number of male/ female members of the scheme:** 287

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 2,096 (Target population: the whole population of Fandène village)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
Information not available

11. **Place of residence for the majority of members:**
**X** rural area

12. **Geographical area covered by the health micro-insurance scheme:**
**X** commune/village

13. **Type of basic health care services covered by the scheme:**
**X** outpatient care: urgent consultation, 100%
**X** hospital treatment: 100% for 10 days hospitalisation; major surgery, 50%
**X** midwife services/ reproductive health care: surgical delivery, 75%.
**X** others: The hospital (Hôpital Saint Jean de Dieu) gives 50% discount to all health services not covered by the mutual.

14. **Method of financing the health insurance:**
**X** members' contributions: 1,000 CFA Franc membership fee and a monthly premium of 200 CFA Franc per person. Family members who may join are the spouse, the children and direct ascendants.

15. **Members' participation in the management of the scheme:**
**X** democratic administration of the scheme by members (general assembly): General assembly, the governing body, the control committee meet frequently. The mutual is managed by 5 permanent volunteers. It has no office.

16. **External technical assistance**
Information not available

17. **Others (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
The Fandène mutual is a pioneer in Senegal. It is well-organised, providing quality insurance benefits and all the villagers of Fandene are its members. However, it encounters some difficulties in collecting its premiums and for several months it faces management problems and an internal crisis.

**-Any bibliographical and written references:**
Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

ABDARAHMANE,S. (1994):Une expérience originale d'assurance maladie des paysans. La mutuelle de santé de Fandène –région de Thiès (Sénégal), CESAG,1994,134p

TINE,J. (1999) la problématique du recouvrement des dépenses de santé de santé en milieu rural sénégalais:les mutuelles de santé de Fandène,Lalane, Diassap et leur impact sur le recours aux structures de soins modernes. Cheikh Anta Diop university,1999,70p

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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## V. Fissel

Note: There is no credible information on this scheme.

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** Communauté rurale de FISSEL
   ***Telephone:*** +221-973 64 45

3. **Contact person:**
   Ibrahima FAYE, President
   Hélène THIAW, Manager

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up:** May 1996

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** August 1996

7. **Total number of male/ female members of the scheme:** 226

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 2,403 (Target population: The whole population of rural FISSEL community)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** rural area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village

**13. Type of basic health care services covered by the scheme:**

**X** outpatient care: consultation 100%

**X** medicines: 100%

**14. Method of financing the health insurance:**

**X** members' contributions: 1,000 CFA Franc membership fee, and monthly premium of 25 CFA Franc per person. Family members who may join are spouse(s), the children and direct ascendants.

**X** others: Donation of 120,000 CFA Franc in 1996

**15. Members' participation in the management of the scheme:**

**X** democratic administration of the scheme by members (general assembly): General assembly, the governing body, the control committee meet frequently. The mutual is managed by three permanent volunteer. It has no office.

**16. External technical assistance**

Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

It is organised inadequately and the management is particularly weak. Moreover, it suffers from low level of subscription and there is no co-ordination between the mutual association and the health service providers.It is no longer offering health services to its members. In terms of the level of debt, this mutual is practically bankrupt.

**-Any bibliographical and written references:**

Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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# VI. Gandiol Santé

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Gandiol Santé

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**

***Address:*** BP 154 St Louis, Sénégal

***Telephone:***--

**3. Contact person:**

Dr Serge ROCHE

**4. Type of organization responsible for the HMIS:**

**X** mutual benefit society

**5. Year (and month) when the scheme was (formally) set up:** February 1997

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** February 1997

7. **Total number of male/ female members of the scheme:** 125

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 1000 (Target population: all inhabitants of Gandiole). 2% of them are women.

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** rural area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village (several villages)

13. **Type of basic health care services covered by the scheme:**
    **X** outpatient care: consultation 100%
    **X** hospital treatment: ( includingh prescriptions)
    **X** midwife services/ reproductive health care: delivery 100%
    **X** medicines: generic drugs 100%
    Note: There is a two-month waiting period.

14. **Method of financing the health insurance:**
    **X** members' contributions: annual premium of 3000 CFA Franc per member (for member with a family. Family members who may join include the spouse(s), the children and direct ascendants.
    **X** others:(gift):Mutualité chretienne de Belgique
    :Mutuelle du trésor de Vendée
    :private donations

15. **Members' participation in the management of the scheme:**
    **X** democratic administration of the scheme by members (general assembly): General assembly, the governing body, the control committee meet frequently.

16. **External technical assistance**
    **X** receives regular external technical assistance

17. **Others (if applicable):**
    **-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
    It is a young mutual that has just started it activities on 1997. The population has confidence on its managers while it recognises the difficulties in collecting premiums.

    **-Any bibliographical and written references:**

Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**
http://www.concertation.org

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## VII. Goxu Mbaaj

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Mutuelle de santé Goxu Mbaaj

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** CNC de nutrition Goxu Mbaaj, St Louis, Senegal
   ***Telephone:*** +221-961-21-65

3. **Contact person:**

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up:** 11th July 1999

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 9th November 1999

7. **Total number of male/ female members of the scheme:** 160

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 640

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** urban area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village

13. **Type of basic health care services covered by the scheme:**
    **X** hospital treatment: 100% (10 days)
    **X** midwife services/ reproductive health care
    **X** medicines: generic medicines
    Note: There is a 3-month waiting period

14. **Method of financing the health insurance:**

X members' contributions: 1000 CFA Franc membership fee, and monthly premium of 500 CFA Franc per person; family members who may join include the spouse(s), children and direct ascendants.

**15. Members' participation in the management of the scheme:**

X democratic administration of the scheme by members (general assembly): General assembly and the governing body meet frequently. The mutual is managed by 3 permanent volunteers .The scheme does not have an office

**16. External technical assistance**

X receives regular external technical assistance

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

The mutual enjoys strong commitments from its administrators and the spirit of solidarity that exists among families. On the other hand, the administrators are lack of training on insurance administration and they experienced difficulties in collecting premiums. The mutual employs an existing medical dispensary store at Goxu Mbaaj and nurses from the army.

**-Any bibliographical and written references:**

Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

http://www.concertation.org

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# VIII. Koudiadiène

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Mutuelle de santé de Koudiadiène

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**

***Address:*** s/c de la Mission Catholique de Koudiadiene, BP 3090 Thiès, Senegal
***Telephone:*** +221-951 1381
***Fax:*** +221-951 4769

**3. Contact person:**

Georges THIAW, President and manager

**4. Type of organization responsible for the HMIS:**

X mutual benefit society

**5. Year (and month) when the scheme was (formally) set up:** 18th July 1993

**6. Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 1st January 1996

**7. Total number of male/ female members of the scheme:** 400.

**8. Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 2,227 (Target population: inhabitants of 5 villages that form the mutual. These villages are Koudiadiène, Thiafath, Lam-Lam, Thiaoune et Ndiobène)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
Information not available

11. **Place of residence for the majority of members:**
**X** rural area

12. **Geographical area covered by the health micro-insurance scheme:**
**X** commune/village

13. **Type of basic health care services covered by the scheme:**
**X** hospital treatment: 15 days hospitalisation at 100% (a daily lump-sum of 3,500 CFA Franc for all hospital related treatment except surgery)
**X** midwife services/ reproductive health care: delivery with complication 100%
**X** others: The insured also benefits from discount on certain health services provided by L' hôpital Saint Jean de Dieu.

14. **Method of financing the health insurance:**
**X** members' contributions: 1,000 CFA Franc membership fee, and monthly premium of 100 CFA Franc per person. Family members who may join are the spouse(s), the children and direct ascendants.
**X** others: In 1996, there was a donation of 200,000 CFA Franc and another 800,000 CFA Franc from lucrative activities.

15. **Members' participation in the management of the scheme:**
**X** democratic administration of the scheme by members (general assembly): General assembly and the governing body meet frequently. There is no a control committee. The mutual is managed by 8 temporary volunteers. It has no office.

16. **External technical assistance**
Information not available

17. **Others (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
This mutual was created in 1993 but did not start its operation until 1996. It has a satisfactory organization system and has kept good documentation record. Due to support is given by the health centre, the mutual does not have to refer patients to a hospital unless it is necessary.

However, the mutual suffers from low level of subscription which explains why it has to resort to other sources of finance. It also did not receive payments from some of its loans. Also, there is communication problem among the 8 villages that form the mutual.

**-Any bibliographical and written references:**

Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**
http://www.concertation.org

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## IX. Lalane Diassap

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Lalane Diassap

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
***Address:*** BP 3055 Lalane, Thiès Escale, Senegal
***Telephone:*** +221-951 47 69

3. **Contact person:**
Thomas DIOP, President
Pierre Gana DIOP, Manager

4. **Type of organization responsible for the HMIS:**
**X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up: 1st** January 1994

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 19th February 1996

7. **Total number of male/ female members of the scheme:** 250

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 1196 (Target population: All inhabitants of Lalane, Diassap, Pognène and a part of Médina Fall of Thiès, which is around 1,791people).

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
Information not available

11. **Place of residence for the majority of members:**
**X** rural area
**X** urban surroundings

12. **Geographical area covered by the health micro-insurance scheme:**
**X** commune/village

13. **Type of basic health care services covered by the scheme:**
**X** hospital treatment: 15 days at 100% (a daily lump-sum of 3,500 CFA Franc for all hospital related treatment except surgery, radiology and medical test)

X others: L'Hôpital Saint Jean de Dieu agreed to give discount on other health services to the insured.

**14. Method of financing the health insurance:**

X members' contributions: 1,000 CFA Franc membership fee, and monthly premium of 150 CFA Franc per person. Family members who may join are spouse(s), the children and direct ascendants.

X non-state subsidies from development agencies, donors etc.: In 1995, ENDA gave 550,000 CFA Franc of subsidy.

**15. Members' participation in the management of the scheme:**

X democratic administration of the scheme by members (general assembly): General assembly and the governing body meet frequently. There is no a control committee. The mutual is managed by 14 temporary volunteers. It has no office.

**16. External technical assistance**

Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

This mutual is well managed and its documents are well kept. It enjoys a high subscription rate and the voluntary spirit of the managers. However, it experiences difficulties in collecting premiums.

**-Any bibliographical and written references:**

Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

For more information, please go to http://www.concertation.org

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## X. Mboro

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Mutuelle de santé de Mboro

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**

***Address:***s/c M. Raymond Diande, paroisse Jésus Ouvrier de Mboro, Thiès, Senegal.

***Telephone:*** +221- 955 7818

**3. Contact person:**

Henry SAW, President

**4. Type of organization responsible for the HMIS:**

X mutual benefit society

**5. Year (and month) when the scheme was (formally) set up:** 24th August 1996

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 24th September 1998

7. **Total number of male/ female members of the scheme:** 242

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 1,116 (Target population: all inhabitants of the rural community of Mboro, more than 10,000 inhabitants)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
Information not available

11. **Place of residence for the majority of members:**
**X** urban area

12. **Geographical area covered by the health micro-insurance scheme:**
**X** commune/village

13. **Type of basic health care services covered by the scheme:**
**X** hospital treatment: 10 days at 100%

14. **Method of financing the health insurance:**
**X** members' contributions: 1,000 CFA Franc membership fee, and monthly premium of 100 CFA Franc per person; family members who may join include the spouse(s), children less than 25 years old and direct ascendants.

15. **Members' participation in the management of the scheme:**
**X** democratic administration of the scheme by members (general assembly): General assembly, the governing body, the control committee meet frequently. The mutual is managed by 8 temporary volunteers It does not have an office.

16. **External technical assistance**
Information not available

17. **Others (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
This is a young mutual that has not started its activities. The premium collection rate is relatively good and the mutual managed to include health care personnel in its operation. It had planned to start the hospital treatment coverage in 1998 and later extend the coverage to other benefits.

**-Any bibliographical and written references:**
Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**
**http://www.concertation.org**

# XI. Médina Gounass

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Mutuelle de santé de Médina Gounass

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** BP 19002, Guédiawaye Dakar, Dakar, Senegal
   ***Telephone:*** +221-837 0511

3. **Contact person:**

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up:** 1st May 1998

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 1st July 1999

7. **Total number of male/female members of the scheme:** 74

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 210, 40% of them are women. (Target population: the whole area of Médina Gounass)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** urban area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village

13. **Type of basic health care services covered by the scheme:**
    **X** preventive care and health promotion
    **X** out-patient care: primary health care, health care for children
    **X** hospital treatment
    Note: there is a 6-month waiting period

14. **Method of financing the health insurance:**
    **X** members' contributions: monthly premium of 205 CFA Franc

15. **Members' participation in the management of the scheme:**
    Information not available

16. **Technical assistance**

**X** receives regularly external technical assistance: it received assistance from the mission française de cooperation at the start of the programme.

17. **Other (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
Mutuelle de santé de Médina Gounass carries the name of the area in order to encourage local residents to participate in the project. Wally Daan Association, an association that promotes women's concerns and the youth wing of the Mission de coopération française have helped the mutual to be established.

**-Any bibliographical and written references:**
http://www.concertation.org

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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## XII. Mont Rolland

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Mont Rolland

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
***Address:*** BP 3025 Thiès Escale, Senegal
***Telephone:*** +221-956 48 13, +221-955 94 01

3. **Contact person:**
Marcel DIOUF, President
Odile THIOMBANE, Manager

4. **Type of organization responsible for the HMIS:**
**X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up:** January 1996

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** May 1996

7. **Total number of male/ female members of the scheme:** 446

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 2,800 (Target population: all inhabitants of the rural community of Mount Rolland)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
Information not available

11. **Place of residence for the majority of members:**

**X** rural area

**12. Geographical area covered by the health micro-insurance scheme:**

**X** commune/village

**13. Type of basic health care services covered by the scheme:**

**X** hospital treatment: 15 days at 100% (a daily lump-sum of 3,500 CFA Franc for all hospital related treatment at Saint Jean de Dieu except surgery)

**X** others: For all the health service not covered by the mutual, l'Hôpital Saint Jean de Dieu gives the insured 50% discount. After 15 days, the mutual may advance money to the subscriber for a health service and be reimbursed later.

**14. Method of financing the health insurance:**

**X** members' contributions: 1,000 CFA Franc family membership fee and monthly 100 CFA Franc per person. The insurance is restricted to 18 persons in a family.

**X** others: A donation of 300,000 CFA Franc in 1996.

**15. Members' participation in the management of the scheme:**

**X** democratic administration of the scheme by members (general assembly): General assembly, the governing body, the control committee meet frequently. The mutual is managed by 4 permanent volunteers. It has no office.

**16. External technical assistance**

Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

Despite of its youth, this mutual is one of the best managed mutuals in terms of organization system as well as benefits and premiums management. The follow-up documents of beneficiaries are well kept and almost all the villagers from the village subscribe to the health insurance. There is a real trust from the population towards the mutual.

However, it has experienced difficulties in collecting premiums and getting back the loans that it has advanced to members.

**-Any bibliographical and written references:**

Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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## XIII. Multi Assistance de l'Education

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** Lycée Seydou Nourou Tall, BP 15 880 Dakar, Senegal
   ***Telephone:*** +221 – 820 19 37, 837 60 85, 822 6974, 957 1533

3. **Contact person:**
   Mansour AW, President
   Ababacar NIANG, Manager

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up:** February 1987

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** December 1993

7. **Total number of male/ female members of the scheme:** 812

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** around 1,500 (Target population: all the National Education personnel and their families)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members**
    **X** rural area
    **X** urban area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** national

13. **Type of basic health care services covered by the scheme:**
    **X** hospital treatment: 20%, 80% is paid by the state
    **X** medicines: 20%, 80% is paid by the state

14. **Method of financing the health insurance:**
    **X** members' contributions: Membership fee is 10,000 CFA Franc and monthly premium is 2,000 CFA Franc, covering the subscriber, the spouse, and 3 children.

15. **Members' participation in the management of the scheme:**
    **X** democratic administration of the scheme by members (general assembly): General assembly, the governing body, the control committee meet frequently. The mutual is managed by 12 temporary personnel and does not have its own office.

16. **External technical assistance**
    Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

The target population of the mutual association are civil servants and they have stable income. Details in the management documents are brief but reasonably well kept.However, the premiums rates are relatively high as compared to those offered by other mutuals and with limited benefits payment. Despite of the nature of its membership, the mutual has experienced late payment problem. The financial performance of this mutual cannot be determined as financial evaluation was not able to be carried out by the researcher due to a lack of documents of accounts.

**-Any bibliographical and written references:**

Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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## XIV. Mutuelle de Yoffe or Dimeli Yoff

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Mutuelle de Yoffe

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**
***Address:*** Centre social, quartier Dagoudane, Yoff

**3. Contact person:**
Mansour SAMBE (Tel: +221- 820 04 65), President
Alioune SARR, Manager

**4. Type of organization responsible for the HMIS:**
**X** mutual benefit society

**5. Year (and month) when the scheme was (formally) set up:** July 1993

**6. Year (and month) when the scheme began to deliver the first benefits to beneficiaries:**
November 1993

**7. Total number of male/ female members of the scheme:** 133

**8. Total number of members in the organization that has set up the scheme:**

**9. Total number of current male/ female beneficiaries of the scheme:** 666 (Target population: 1,200 families, which is the whole village)

**10. Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
Information not available

**11. Place of residence for the majority of members**
**X** urban area

**12. Geographical area covered by the health micro-insurance scheme:**
**X** commune/village

**13. Type of basic health care services covered by the scheme:**
**X** preventive care and health promotion
**X** outpatient care: consultation 100%
**X** medicines: 100%

**14. Method of financing the health insurance:**
**X** members' contributions 1,000 CFA Franc membership fee, and monthly premium of 200 CFA Franc per family covering the subscriber, the spouse(s) and 3 children. A monthly supplementary of 200CFA Franc for additional child (US$1=614 CFA Franc, Aug. '99)

**15. Members' participation in the management of the scheme:**
**X** democratic administration of the scheme by members (general assembly): General assembly, the governing body, the control committee meet frequently. The mutual is managed by 4 permanent volunteer and has its own office.

**16. External technical assistance**
Information not available

**17. Others (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
Dimeli Yoff is a traditional mutual noted for the solidarity among its members. The mutual has good organization system, with different units of the mutual meet regularly and follow-up documents of beneficiaries are well kept. However, it has late payment problem. If all premiums are paid on time, it would have greatly increased the number of subscribers of the scheme. The mutual has conducted a study on how to enlarge its membership base. One of its plans is to make contracts with other health providers.

**-Any bibliographical and written references:**
Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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## XV. Mutuelle des Volontaires de l'Education

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Mutuelle des Volontaires de l'Education

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**
***Address:*** Direction de l'alphabétisation, BP 15 742 Tour de l'œuf DAEB, Point E, Dakar, Senegal.
***Telephone:*** +221 – 825 39 83, 635 9079
***Fax:*** +221 – 825 39 83

**3. Contact person:**
Cheikh WILANE, President

Kassory KANTE, Manager

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up:** December 1995

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** December 1995
7. **Total number of male/ female members of the scheme:** 3,703

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 3,703 (Target population: All the national education volunteers)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** rural area
    **X** urban area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** national

13. **Type of basic health care services covered by the scheme:**
    **X** hospital treatment: 100%
    **X** medical evacuations: 100%

14. **Method of financing the health insurance:**
    **X** members' contributions: Annual premium is 10,000 CFA Franc, and it does not cover the family. Payment are deducted from salary.

15. **Members' participation in the management of the scheme:**
    **X** democratic administration of the scheme by members (general assembly) ): General assembly, the governing body, the control committee meet frequently. Two full-time employees are responsible for the management of the mutual. The mutual has an office.

16. **External technical assistance**
    Information not available

17. **Others (if applicable):**
    **-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
    This mutual is well managed and has a good financial base. Premiums collection rate is satisfying and its financial solvency has created confidence among health service providers. During the first year, some 2,400 members have subscribed for 4 years, contributing some

40,000 CFA Franc per person. The outlook of the insurance scheme is good, as the beneficiaries are young and healthy.

Weaknesses are:

- family coverage is not available
- obligatory membership and withdrawals of 4 years worth of premiums from salary has elicited negative reactions from the volunteers

In the mean time, the mutual is contemplating on setting a limit to the extent of hospitalisation coverage in order to provide other types of insurance benefits in the scheme and extending insurance coverage to include members' families.

**-Any bibliographical and written references:**
Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**
For more information, please go to **http://www.concertation.org**

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## XVI. Mutuelle Sococim Entreprises

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Mutuelle Sococim Entreprises

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** BP 29 Rufisque, Senegal.
   ***Telephone:*** +221 – 836 22 50
   ***Fax:*** +221 – 836 09 81

3. **Contact person:**
   El Hadji Malik KEITA, President
   Omar FAYE, Manager

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up:** 1996

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 1996

7. **Total number of male/ female members of the scheme:** 268

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 1,245 (Target population: All the personnel in the company and their families: 3,000 persons)

**10. Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
Information not available

**11. Place of residence for the majority of members:**
**X** urban area

**12. Geographical area covered by the health micro-insurance scheme:**
**X** commune/village

**13. Type of basic health care services covered by the scheme:**
**X** outpatient care: consultation 50%
**X** hospital treatment: 100% of the 3rd category

**14. Method of financing the health insurance:**
**X** members' contributions: Each family pays 1,400 CFA Franc monthly which covers the subscriber, the spouse(s) and all the children. The premium is deducted from the salary automatically.
**X** others: The company provides annual subsidy of 5,000,000 CFA Franc.

**15. Members' participation in the management of the scheme:**
**X** democratic administration of the scheme by members (general assembly): General assembly, the governing body, the control committee meet frequently. There are two temporary volunteers manage the mutual. The office workers are paid allowances. The premises and materials of the company are at the disposal of the mutual.

**16. External technical assistance**
Information not available

**17. Others (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
The mutual enjoys the infrastructure of the company, but it does not have its own office. The management of documents remained to be improved as only a follow-up premium payment document is available. It appears to have a proper accounting system, and the heavy subsidy from the company puts the mutual in good financial standing, with surplus in the funds.

Other strengths of SOCOCIM mutual:

- The salary of its members are relatively high
- The premiums are deducted automatically from source
- No late payment
- The company provides financial help

However, the level of organization remains weak and the total premiums collected do not cover the costs of benefit payment. There is a company's medical centre and for several years the mutual plans to provide health service by itself. This may allow the mutual to control the cost of health care better than present arrangement. It also plans to insure progressively the whole population of Rufisque.

**-Any bibliographical and written references:**
Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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## XVII. Ngeye Ngeye

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:* s/c Amadou Sidy Ba,** Ngeye Ngeye, Mboro, Thiès, Senegal.
   ***Telephone:*** +221-955 77 19

3. **Contact person:**
   Bou DIOP, President
   Mamadou Sidi BA, Manager

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up:** 5th October 1994

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 15th October 1994

7. **Total number of male/ female members of the scheme:** 225

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 1,210 (Target population: all inhabitants of the rural community of Mboro, 3,600 persons)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** rural area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village

13. **Type of basic health care services covered by the scheme:**
    **X** outpatient care: consultation 20%, primary health care, vaccination
    **X** hospital treatment: hospitalisation 20%; surgery 20%
    **X** midwife services/ reproductive health care: delivery 20%
    **X** medicines: 20%

- X medical evacuations: transport 100%
- X others: laboratory / radiology 20%; dental treatment 20%

This benefits coverage is recognised by other health service providers. Patients, both insured or non-insured, who are treated at the health cabin are required to pay 50 CFA Franc.

**14. Method of financing the health insurance:**

- X members' contributions: For a man, the membership fee is 1,000 CFA Franc, and 500 CFA Franc for a woman. A monthly 200 CFA Franc premium per family if the subscriber is a man. For a woman subscriber, it is 100 CFA Franc. A family includes the subscriber, spouse(s), children less than 20 years old and direct ascendants.
- X others: In 1996, a donation of 100,000 CFA Franc was given from the national lotery.

**15. Members' participation in the management of the scheme:**

- X democratic administration of the scheme by members (general assembly): General assembly, the governing body, the control committee meet frequently. The mutual is managed by 3 temporary volunteers. It has an office.

**16. External technical assistance**

Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

The population finds the mutual credible and it has recruited a good number of members. Moreover, it is well structured. The range of health benefits offered by the mutual is reasonable in terms of the amount of premiums paid by its members. Insufficient funding has prevented the mutual's managers to realise its main objective, which is to construct a health centre.

**-Any bibliographical and written references:**

Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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## XVIII. Pandhienou Léhar

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**

***Address:*** BP19 Mission catholique de Pandhiénou, Tivouane, Thiès, Senegal
***Telephone:*** +221-956 43 46, +221-955 75 04

**3. Contact person:**

Simon DIONE, President
Maurice TINE, Manager

**4. Type of organization responsible for the HMIS:**

**X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up:** 1st January 1995

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 6th July 1999

7. **Total number of male/ female members of the scheme:** 207

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 1,283 (Target population: all inhabitants of Pandienou Lehar parish). No female beneficiaries.

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** rural area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village

13. **Type of basic health care services covered by the scheme:**
    **X** hospital treatment: 8 days at 100% and primary health care
    **X** others: For claims not covered by the mutual, the insured members benefit 50% discount at l'Hôpital Saint Jean de Dieu.

14. **Method of financing the health insurance:**
    **X** members' contributions: 1,000 CFA Franc membership fee, and monthly premium of 100 CFA Franc per person; family members who may join include the spouse(s), the children and direct ascendants.

15. **Members' participation in the management of the scheme:**
    **X** democratic administration of the scheme by members (general assembly): General assembly, the governing body, the control committee meet frequently. The mutual is managed by 6 permanent volunteers It does not have an office.

16. **External technical assistance**
    Information not available

17. **Others (if applicable):**
    **-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
    The mutual has good management and strong involvement from the population. The follow-up documents of beneficiaries are relatively well kept. The managers are aware of the possibilities and limitation of their organization.

    Nevertheless, the mutual has not started to pay out claims and has not faced difficulties in premium collection (notably during winter time).

**-Any bibliographical and written references:**
Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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## XIX. Saint Jean Baptiste

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Mutuelle Saint Jean Baptiste

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** BP 80 Thiès, Senegal
   ***Telephone:*** **+**221-951 23 59

3. **Contact person:**
   Louis-Jérôme DIEDHIOU, President
   Claude Balla FAYE, Manager

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up:** 31st May 1992

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 31st May 1992

7. **Total number of male/ female members of the scheme:** 350

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 1,753 (Target population: all inhabitants of Saint Jean Baptist parish)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** rural area (2 areas)
    **X** urban area (7 areas)

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** department

13. **Type of basic health care services covered by the scheme:**
    **X** hospital treatment: 15 days at 50% (a daily lump-sum of 3,500 CFA Franc for all hospital related treatment except surgery)

X others: L'Hôpital Saint Jean de Dieu agreed to give 50% discount for all laboratory examinations, the radiologies and consultations

**14. Method of financing the health insurance:**

X members' contributions: 1,000 CFA Franc membership fee, and monthly premium of 100 CFA Franc per person. Family members who may join include the spouse(s), the children and direct ascendants.

X others: Lucrative activities

**15. Members' participation in the management of the scheme:**

X democratic administration of the scheme by members (general assembly)**:** General assembly, the governing body, the control committee meet frequently. It does not have an office.

**16. External technical assistance**

Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

This mutual was well managed but a hospitalisation case left it in bankruptcy, forcing it to suspend its benefits payment. Moreover, a conflict with l'Hôpital Saint Jean de Dieu ensued for the delay in payments was estimated at 1,400 000 CFA Franc.

**-Any bibliographical and written references:**

Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

For more information, please go to **http://www.concertation.org**

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## XX. Sanghé

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Mutuelle de santé de Sanghé

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**
***Address:*** BP 97, s/c Mission catholique de Sanghé, Sanghé, Thiès , Senegal.

**3. Contact person:**
André SENN, President
François SENN, Manager

**4. Type of organization responsible for the HMIS:**

X mutual benefit society

**5. Year (and month) when the scheme was (formally) set up:** 1st March 1994

**6. Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 3rd May 1997

7. **Total number of male/ female members of the scheme:** 87

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 461 (Target population: all inhabitants of the 6 villages representing the base of the ecclesiastic committee, around 4,200 persons)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
Information not available

11. **Place of residence for the majority of members:**
**X** rural area

12. **Geographical area covered by the health micro-insurance scheme:**
**X** commune/village

13. **Type of basic health care services covered by the scheme:**
**X** outpatient care: primary health care
**X** hospital treatment: 15 days at 100% (a daily lump-sum of 3,500 CFA Franc for all hospital related treatment except surgery)
**X** others: L'Hôpital Saint Jean de Dieu gave discount to the insured for other health services

14. **Method of financing the health insurance:**
**X** members' contributions: 1,000 CFA Franc membership fee, and monthly premium of 100 CFA Franc per person; family members who may join include the spouse(s), the children and direct ascendants.

15. **Members' participation in the management of the scheme:**
**X** democratic administration of the scheme by members (general assembly): General assembly, the governing body, the control committee meet frequently. The mutual is managed by 5 temporary volunteers It does not have an office.

16. **External technical assistance**
Information not available

17. **Others (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
This mutual has just started its operations. A priest and a nurse help in the management of the mutual. Those in charge are predominantly Catholic and the villagers are predominantly muslims, which may hinder its development. The long distance between the villages (sometimes 10 Kms) make it difficult to collect premiums.

**-Any bibliographical and written references:**
Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

http://www.concertation.org

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## XXI. Soppanté

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Mutuelle de santé Soppanté

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** BP 3055, Fandène, Thiès, Senegal
   ***Telephone:*** +221-951 4769
   ***Fax:*** +221-951 4769

3. **Contact person:**

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up:** 1st May 1997

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 1st October 1998

7. **Total number of male/female members of the scheme:** 355

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 2,500 (Target population: it covers the surrounding villages of Fandène that are divided into 4 zones)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** rural area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village

13. **Type of basic health care services covered by the scheme: Information not available**

14. **Method of financing the health insurance:**
    **X** members' contributions: a monthly premium of 100 CFA Franc per person.

15. **Members' participation in the management of the scheme:**
    Information not available

16. **Technical assistance**
    Information not available

17. **Other (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
It also uses the services provided by l'Hôpital Saint Jean de Dieu

**-Any bibliographical and written references:**
http://www.concertation.org

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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## XXII. Thially

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Mutuelle de Thially

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
***Address:*** BP 3322 THIES Escale, Senegal.
***Telephone:*** +221-951 32 94

3. **Contact person:**
Joseph NIANG, President
Lucien Marcel NDIONE, Manager

4. **Type of organization responsible for the HMIS:**
**X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up:** 1st August 1995

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 1st March 1998

7. **Total number of male/ female members of the scheme:** 142

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 339 (Target population: all inhabitants of Grand Thially)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
Information not available

11. **Place of residence for the majority of members:**
**X** urban area

12. **Geographical area covered by the health micro-insurance scheme:**
**X** commune/village

13. **Type of basic health care services covered by the scheme:**
**X** outpatient care: consultation 100%

- **X** hospital treatment: minor surgery 100%
- **X** midwife services/ reproductive health care: delivery 100%
- **X** medicines: generic drugs 100%

**14. Method of financing the health insurance:**

- **X** members' contributions: 1,000 CFA Franc membership fee, and monthly premium of 200 CFA Franc per person; family members who may join include the spouse(s), children less than 18 years old.

**15. Members' participation in the management of the scheme:**

- **X** democratic administration of the scheme by members (general assembly): General assembly, the governing body, the control committee meet frequently. The executive office is formed by 6 volunteers It does not have an office.

**16. External technical assistance**

Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

It is a young mutual with a lot of enthusiasm and ambition. The solidarity of subscribers and strong motivation of managers are the strengths of the mutual. It seems that it has all the administrative documents on beneficiaries, however, it has already encountered difficulties in collecting premiums. The mutual expects hospital treatments would be provided by l'Hôpital Saint Jean de Dieu.

**-Any bibliographical and written references:**

Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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## XXIII. Wer Werlé (Profemu), Thiès

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Mutuelle santé Wer Werlé

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**

***Address:*** Profemu, Golf Sud , villa 76 L, Thiès, Senegal
***Telephone:*** +221-937 0610

**3. Contact person:**

**4. Type of organization responsible for the HMIS:**

- **X** mutual benefit society

**5. Year (and month) when the scheme was (formally) set up:** 1st June 2000

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 1st June 2000

This health mutual is set up entirely by and for women, as well as their families. It is part of their urban women development programme. Since the programme is very recent, there is no additional information available.

# South Africa

I. Health Insurance Scheme of HOSPERSA

II. National Stokvels Association of South Africa (NASASA)

III. SIZWE Medical Fund

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## I. Health Insurance Scheme of HOSPERSA

*Contact: Hospersa, P.O. Box 3284, Pretoria 0001, South Africa*
*Tel: +27-21-333-6252*
*Fax: +27-21-333-9248*

*Contact: Key Health, Metropolitan Health,*
*Tel: +27-21-940-6550 (Membership Department)*
*Fax:+27-21-940 6313/6984 (Membership Department)*
*Email: membership@methealth.co.za*
*Tel: +27-21-940-6534 (MetHealth News)*
*Fax: +27-21-940-6578 (MetHealth News*
*Tel: +27-21-940-5970 (Switchboard)*
*Email: enquiries@methealth.co.za*
*Web site: http://methealth.co.za/KeyHealth/key_about.asp*

Having observed how Medical Aid Schemes in South Africa were becoming more and more unaffordable to its members, HOSPERSA (Hospital Personnel trade union of South Africa) set up it own health insurance scheme jointly with Metropolitan Health, a private insurance company, in February/ March in 1997. It is called Key Health. That year, they managed to recruit 2,500 members, and the potential membership, which is all the members of HOSPERSA, is around 50,000.

For HOSPERSA's members, the state subsidies two thirds of the actual cost of premiums. The table below shows the amount a state employee is expected to contribute monthly in 1998 for one of the two options plan available. It is a plan with lower benefits coverage.

All figure below are in South African Rand (ZAR)

| Age | Member (M) | M+1 | M+2 | M+3 | M+4 | M+>4 |
|---|---|---|---|---|---|---|
| <20 | 103 | 136 | 154 | 174 | 190 | 204 |
| 20-35 | 116 | 153 | 175 | 197 | 215 | 229 |
| 36-50 | 128 | 171 | 193 | 217 | 240 | 254 |
| 51-80 | 140 | 187 | 213 | 240 | 262 | 281 |
| 61+ | 142 | 195 | 227 | 263 | 289 | 311 |

Data comes from Metropolitan Health.

Private sector employees can also join the scheme by paying the full premium rate (which is simply the above premium rate times 3). One of the advantages of Key Health is that monthly premium contribution is divided into two parts. The first part is allocated 60-82% of the monthly premium, depending on the age and the number of beneficiaries of the policyholder. The premium from this part is used to finance the benefits package that will be shown below. The second part is a medical savings account, whereby unused funds are accumulated and invested by the insurance company, offering a net return of 9% or 12%. All accumulated funds (capital and interests) can be withdrawn by the policyholders at any time. In cases that the annual benefits payment for certain treatments have been exhausted by the beneficiaries, the funds in the medical savings account can be used to pay for the extra consumption.

By incorporating medical savings account in the insurance system, it moderates medical consumption of beneficiaries. Since accumulated fund is invested and offered a good rate of return, there is an incentive not to use this fund when one is still young and/or healthy. Hence risks are not only pooled across beneficiaries, they are also spread throughout the life time of the beneficiaries.

Benefits payments cover treatments sought in both private and public sectors. It also covers expenses related to traditional healers. Chronic illness and medication expenses related to specific chronic illnesses are covered from the very beginning. Benefits coverage for over-the-counter medicine can be obtained by subscribing the the mor expensive option plan.

The following is a table of the annual benefits coverage in 1998

| Benefit Group | Cover | Member | Member +1 | Member +2 | Member +3 | Member +3+ |
|---|---|---|---|---|---|---|
| **1. Hospitalisation** | | | | | | |
| i) Private hospitals | 100% | AOL=R350,000 | AOL | AOL | AOL | AOL |
| ii) Provincial Hospitals | 100% | AOL | AOL | AOL | AOL | AOL |
| iii) Medicine dispensed in hospital | 100% | AOL | AOL | AOL | AOL | AOL |
| **2. General Practitioners** | | | | | | |
| i) Out of hospital | 100% | R400 | R600 | R700 | R800 | R900 |
| ii) In hospital | 100% | AOL | AOL | AOL | AOL | AOL |
| **3. Specialists** | 100% | Joint limit with GP | AOL | AOL | AOL | AOL |
| **4. Medicine** | | | | | | |
| i) Acute medication | 100% of cost from AF after deduction of R10 | 100% of cost from AF | 100% of cost from AF | 100% of cost from AF | 100% of cost from AF | 100% of cost from AF |
| ii) Chronic medication | 100% of cost for specified conditions | R2,000 | R2,000 per family member | 100% of cost from AF | 100% of cost from AF | 100% of cost from AF |
| **5. Dentistry** | | | | | | |
| i) Conservative & specialised dentistry | 100% of cost from AF | 100% of cost from AF | 100% of cost from AF | 100% of cost from AF | 100% of cost from AF | 100% of cost from AF |

| | | | | | | |
|---|---|---|---|---|---|---|
| ii) Maxillo facial | 100% | AOL | AOL | AOL | AOL | AOL |
| **6. Optical** | 100% of cost from AF | 100% of cost from AF | 100% of cost from AF | 100% of cost from AF | 100% of cost from AF | 100% of cost from AF |
| **7. X-rays & Pathology** | See specialists | See specialists | See specialists | See specialists | See specialists | See specialists |
| **8. Radiotherapy & Chemotherapy** | 100% | AOL | AOL | AOL | AOL | AOL |
| **9. Blood transfusion** | 100% | AOL | AOL | AOL | AOL | AOL |
| **10. Ambulance** | 100% | R600 per case, max. R1,000 | R600 per case, max. R1,000 | R600 per case, max. R1,000 | R600 per case, max. R1,000 | R600 per case, max. R1,000 |
| **11. Internal Prothesis** | See hospital | R5,000 | R5,000 | R5,000 | R5,000 | R5,000 |
| **12. Surgical Appliances** | 100% | R1,000 | R1,000 | R1,000 | R1,000 | R1,000 |
| **13. Organ Transplants and Dialysis** | 100% | R50,000 | R50,000 | R50,000 | R50,000 | R50,000 |
| **14. Chiropractor, homeopath, naturopath** | 80% | Joint limit with GP | Joint limit with GP | Joint limit with GP | Joint limit with GP | Joint limit with GP |
| **15. Auxilliary services** | 100% of cost from AF | 100% of cost from AF | 100% of cost from AF | 100% of cost from AF | 100% of cost from AF | 100% of cost from AF |
| **16. Hearing Aids** | 100% of cost from AF | 100% of cost from AF | 100% of cost from AF | 100% of cost from AF | 100% of cost from AF | 100% of cost from AF |
| **17. Self Care Kit** | Provision for quality famiy self medication home care | | | | | |
| **18. Pre-funding component** | To build funds for health care at retirement | | | | | |

AF = Accumulation Fund

AOL = Annual Overall Limit: ZAR350,000 including sub-limits for benefit items as specified

Auxillary Services = clinical speech and occupational therapists, physiotherapists, podiatrists, psychologists, orthoptists, audiologists, dieticians and masseurs.

**Reference:**

Atim, C. (1998) *WSM Mutuals' Identification Mission to: Ethiopia, Tanzania, Zimbabwe, South Africa, Full Mission Report.*

Metropolitan Health's web site at http://methealth.co.za/KeyHealth/key_about.asp

# II. National Stokvels Association of South Africa (NASASA)

*Contact: NATIONAL STOKVELS ASSOCIATION OF SOUTH AFRICA (NASASA)*
*Postal Address: P.O. BOX 130459, BRYANSTON, 2021*
*Street Address: 4TH FLOOR, 32 DIAGONAL STREET, EASTWING, JOHANNESBURG*
*Persons to contact: PRESIDENT, Mr A Lukhele, Mr M Phatlane, Mr S Mokgoatsane*
*PHONE: +27-11-832 1054*
*FAX: +27-11-838 1624*

Stokvels are informal solidarity groups (or self-help groups) that offer many kinds of service, including rotating credit and savings (à la tontinière), funeral insurance, social occasions or parties etc. A study in 1989 estimated that there were about 24,000 stokvels in the major metropolitan areas, with some 680,000 members contributing about ZAR52 million (US$1=ZAR6, September '99). Members meet frequently and 60% of the members were female.

NASASA was set up in 1988 as a lobby and umbrella group to represent the interests of these associations. It is a non-profit-making organization. It provides education and public awareness programmes to low income communities, encouraging them to save with the self-managed stokvels. It also develops management training materials for members of stokvels.

Members of a stokvel or other social groups can join NASASA by paying an annual fee of ZAR30. A stokvel can be affiliated to NASASA by paying ZAR1,500 subscription fee and ZAR850 annual renewal fee thereafter. As an affiliate, a stokvel has to agree to operate their business according to a code of conduct drawn up by NASASA. In 1997, there were about 16,000 stokvels registered with NASASA nationwide.

Individual members can subscribe to NASASA's funeral insurance for an annual premium of only ZAR148 (about US$24). The insurance benefit is ZAR3,000, and the scheme automatically covers a member's immediate family, including his multiple spouses. It has a waiting period of 3 months.

A few volunteers managed NASASA initially. Now it has gathered enough income from its premiums on funeral insurance scheme to employ a secretary, a finance officer and an insurance administrator. Other working officers are still non-paid.

**Reference:**

Atim, C. (1998) *WSM Mutuals' Identification Mission to: Ethiopia, Tanzania, Zimbabwe, South Africa, Full Mission Report.*

# III. SIZWE Medical Fund

*Contact: Sizwe Medical Fund, Sizwe Medical Services, P O Box 260709, Excom 2023, South Africa*
*Tel: + 27-11-353 0000, 329 0533*
*Fax: +27-11-331-9390, 789 3968*
*Dr AJ Khomo, Medical Director*
*Mr Andrew M Jackson, Joe Seoloane, Principal Officer*

Sizwe (Nation) Medical Fund is set up by a group of black doctors, including Dr Nthatho Motlana and a handful of other Sowetan doctors in 1978, exclusively for the black people who live in poor townships. In the 1980's, the fund began to accept members from all other ethnic groups.

The membership is predominantly made up of blue collar black workers. It has 60,419 principal members and 132,327 dependants in 1998. Sizwe obtains most of its members by offering package deals for group membership to trade unions and employers of blue collar workers. However, the health insurance contracts are arranged with the individual.

Sizwe follows mutualist principles, offering community rated premium related only to member's income and the number of dependants and not his/her personal risks. The scheme also allows members of an extended family (aged parents, grand children) to be registered for only 50% of the normal family premium rate.

The following table shows the monthly premium rates for the Affordable Option in 1997

| **Basic monthly salary (ZAR)** | Contribution according to the number of dependants | | | | | | |
|---|---|---|---|---|---|---|---|
| | Member only | M+1 | M+2 | M+3 | M+4 | M+5 | M+6 |
| <300 | 138 | 279 | 300 | 318 | 338 | 359 | 393 |
| 301-500 | 196 | 396 | 418 | 438 | 461 | 482 | 515 |
| 501-800 | 245 | 486 | 504 | 525 | 549 | 572 | 605 |
| 801-1,000 | 248 | 495 | 515 | 536 | 563 | 586 | 618 |
| 1,001-1,200 | 255 | 512 | 533 | 554 | 578 | 599 | 634 |
| 1,201-1,500 | 297 | 594 | 666 | 674 | 701 | 718 | 753 |
| 1,501-2,000 | 356 | 702 | 772 | 804 | 843 | 880 | 912 |
| 2,001-2,500 | 358 | 717 | 790 | 821 | 860 | 896 | 929 |
| 2,501-3,000 | 374 | 744 | 820 | 857 | 893 | 932 | 965 |
| 3,001-4,000 | 407 | 818 | 885 | 923 | 963 | 977 | 1,011 |
| 4,001-5,000 | 417 | 843 | 912 | 951 | 992 | 1,006 | 1,041 |
| >5,001 | 432 | 868 | 939 | 979 | 1,022 | 1,036 | 1,073 |

Figures from Chris Atim's mission report

Benefits of the scheme includes freedom to attend any medical facility, private or public when needed, as well as funeral insurance as an automatic benefit of membership.

The following table shows the benefits payment (as of 01/01/97), in Rand

| **Benefit & membership category** | Sizwe Primary Care | Sizwe Affordable | Sizwe Full Benefit |
|---|---|---|---|
| **GP consultations & visits** | Overall Annual Limits | Overall Annual Limits | Overall Annual Limits |
| Member 00 | 500 | 875 | 1,250 |
| Member 01 | 1,250 | 1,700 | 2,000 |
| Member 02 | 1,500 | 1,900 | 2,500 |
| Member 03 | 1,750 | 2,150 | 2,875 |
| Member 04 | 2,000 | 2,400 | 3,500 |
| Member 05 | 2,000 | 2,500 | 3,500 |
| **Acute medicines:** | | | |
| Member 00 | 900 | 1,650 | 2,000 |
| Member 01 | 1,700 | 2,500 | 3,500 |
| Member 02 | 1,900 | 3,000 | 4,000 |
| Member 03 | 2,100 | 3,500 | 4,500 |
| Member 04 | 2,200 | 4,000 | 5,000 |
| Member 05 | 2,500 | 4,000 | 5,500 |
| **Funeral policy** | | | |
| Member | 1,500 | 5,000 | 5,000 |
| Spouse | 1,500 | 5,000 | 5,000 |
| Own child, 14-21 years old | 1,500 | 5,000 | 5,000 |
| Own child, 6-13 years old | 1,000 | 1,500 | 1,500 |
| Own child, 1-5 years old | 750 | 1,000 | 1,000 |
| Own child, 0-11 months | 250 | 500 | 500 |

Figures from Chris Atim's mission report

It is Sizwe Medical Service that administers Sizwe Medical Fund. It adopts grassroots approach to its management, ensuring community representation in their regional committees.

In 1997, Sizwe initiated a local managed health care delivery system in the Eastern cape as a response to the increasing dissatisfaction to increasing health care cost in the region. It set up agreements with a large network of health care providers who would be reimbursed at a fix rate after beneficiaries used its service. With this arrangement, Sizwe has successfully achieved cost containment.

**Reference:**

http://www.woza.co.za/comps/sizweo.htm

Atim, C. (1998) *WSM Mutuals' Identification Mission to: Ethiopia, Tanzania, Zimbabwe, South Africa, Full Mission Report.*

# Tanzania

I. Bumbuli Hospital's Community Health Fund
II. Bunda Designated District Hospital's Community Health Fund
III. Mburahati Health Trust Fund
IV. Selian Hospital Insurance Scheme
V. Tusaidiane Bima Ya Afya Ya Atiman
VI. UMASIDA

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## I. Bumbuli Hospital's Community Health Fund

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Health Directorate of the Evangelical Lutheran Church in Tanzania (ELCT)

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   **Address:** ELCT, P.O.Box 3033, Arusha, Tanzania
   **Telephone:** +255-57-8855/ 8856/ 8857/ 4427
   **Email:** markbura@yako.habari.co.tz
   **Fax:** +255-57-8858
   **Website:** http://www.habari.co.tz/ELCT.Health/

3. **Contact person:** Dr. Mark Bura (ELCT Health Programme Director)

4. **Type of organization responsible for the HMIS:**
   **X** non-profit health care provider: this missionary hospital is owned by Evangelical Lutheran Church of Tanzania (ELCT)

5. **Year (and month) when the scheme was (formally) set up:** 29th February 1999

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** March 1999

7. **Total number of male/female members of the scheme:** 21

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 21

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** rural area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village

13. **Type of basic health care services covered by the scheme:**
    **X** out-patient care
    **X** hospital treatment

14. **Method of financing the health insurance:**
    **X** members' contributions

15. **Members' participation in the management of the scheme:**
    **X** democratic administration of the scheme by members (general assembly): Bumbuli Hospital Community Health Fund is a partnership fund between the communities and the hospital. The trustees who represent the communities have 60% of the representation in the trust fund.

16. **External technical assistance**
    Information not available

17. **Others (if applicable):**
    **-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

    **-Any bibliographical and written references:**
    http://www.habari.co.tz/ELCT.Health/

    **-Names of persons and/or organizations that can provide additional information about the scheme:**

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# II. Bunda Designated District Hospital's Community Health Fund

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Health Directorate of the Evangelical Lutheran Church in Tanzania (ELCT)

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   **Address:** ELCT, P.O.Box 3033, Arusha, Tanzania
   **Telephone:** +255-57-8855/ 8856/ 8857/ 4427
   **Email:** markbura@yako.habari.co.tz, ELCTHQ@habari.co.tz
   **Fax:** +255-57-8858
   **Website:** http://www.habari.co.tz/ELCT.Health/

3. **Contact person:** Dr. Mark Bura (ELCT Health Programme Director)

4. **Type of organization responsible for the HMIS:**
   **X** non-profit health care provider: this missionary hospital is owned by Evangelical Lutheran Church of Tanzania (ELCT)

5. **Year (and month) when the scheme was (formally) set up:** 16th July 1999

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** July 1999

7. **Total number of male/female members of the scheme:** salaried workers include hospital staff and workers of the nearby cotton gineries.

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** unknown (Target population: Population of Bunda town and nearby villages)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** rural area
    **X** urban area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village

13. **Type of basic health care services covered by the scheme:**
    **X** out-patient care
    **X** hospital treatment

14. **Method of financing the health insurance:**
    **X** members' contributions
    **X** non-state subsidies from development agencies, donors etc.: NORAD subsidies the operational cost of the Community Health Fund.

15. **Members' participation in the management of the scheme:**
    **X** administration by the organization responsible for the administration of the HMIS without members' participation other than choice of health services covered.

16. **External technical assistance**
    Information not available

17. **Others (if applicable):**
    **-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

**-Any bibliographical and written references:**

http://www.habari.co.tz/ELCT.Health/

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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## III. Mburahati Health Trust Fund

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Mburahati Health Trust

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**

3. **Contact person:**

4. **Type of organization responsible for the HMIS:**
   **X** co-operative-type organization

5. **Year (and month) when the scheme was (formally) set up:** 1998

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 1998

7. **Total number of male/female members of the scheme:**

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:**

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** urban area

12. **Geographical area covered by the health micro-insurance scheme:**
    Information not available.

13. **Type of basic health care services covered by the scheme:**
    **X** out-patient care: free consultation
    **X** hospital treatment: 10% of hospital cost
    Note:
    - A medical service provider offers its service under a contract.
    - The members of the Mburahati Health Trust Fund have decided on a waiting period of three months.

14. **Method of financing the health insurance:**
    **X** members' contributions: US$53 per family of four per year

15. **Members' participation in the management of the scheme:**

**X** democratic administration of the scheme by members (general assembly): The insurance is managed by the members via a co-operative society.

**16. External technical assistance**

**X** receives regular external technical assistance: technical and financial assistance is given by SSMECA (Strengthening Small and Micro Enterprises and their Co-operatives/ Associations) of ILO in the initial stage of set up.

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

Local community is involved in defining the health insurance system. With three months of waiting period, it allows financial reserves to be accumulated and a member's honesty in his/her insurance declaration be checked.

**-Any bibliographical and written references:**

Debaig, G. (1999) Report on the "Community Based Health Insurance Regional Conference" at Kampala, Uganda, on 9-13 November 1998.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

Mrs. A.M. van Oss, ILO/SSMECA, P.O. Box 9212, Dar es Salaam, Tanzania
Telephone: +255-51-153 115
Fax: +225-51-666 004
Email: SSMECA@intafrica.com

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## IV. Selian Hospital Insurance Scheme

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Health Directorate of the Evangelical Lutheran Church in Tanzania (ELCT)

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**
**Address:** ELCT, P.O.Box 3033, Arusha, Tanzania
**Telephone:** +255-57-8855/ 8856/ 8857/ 4427
**Email:** markbura@yako.habari.co.tz
**Fax:** +255-57-8858
**Website:** http://www.habari.co.tz/ELCT.Health/

**3. Contact person:** Dr. Mark Bura (ELCT Health Programme Director)

**4. Type of organization responsible for the HMIS:**

**X** non-profit health care provider: this missionary hospital is owned by Evangelical Lutheran Church of Tanzania (ELCT)

**5. Year (and month) when the scheme was (formally) set up:** 1997

**6. Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 1997

7. **Total number of male/female members of the scheme:**

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:**

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    - **X** rural area
    - **X** urban area
    - **X** urban surroundings

12. **Geographical area covered by the health micro-insurance scheme:**
    - **X** commune/village: the community-based health care and health insurance are provided to nearby villages

13. **Type of basic health care services covered by the scheme:**
    - **X** preventive care and health promotion: it works with traditional birth attendants in AIDS education and prevention
    - **X** out-patient care: outpatient consultation
    - **X** hospital treatment: it provides full service and has 100 beds

    Note: The coverage of the health care benefits is decided upon by the doctors based on public health criterias.

14. **Method of financing the health insurance:**
    - **X** members' contributions: US$23 per person per year

15. **Members' participation in the management of the scheme:**
    - **X** administration by the organization responsible for the administration of the HMIS without members' participation other than choice of health services covered.

16. **External technical assistance**
    Information not available

17. **Others (if applicable):**
    **-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
    Selian Hospital is one of the seven ELCT rural hospitals (others are Ndolage Hospital, Bunda Hospital, Machame Hospital, Bulongwa Hospital, Itete Hospital and Bumbuli Hospital) that have participated in a management efficiency programme called Managed Health Care Programme. Under this programme, a Health Management Information System (HMIS) software package is installed in all seven hospitals, and the hospitals are provided with extra computers. All these computers are networked with each other. So on the minute monitoring of services and revenue collection are then made possible. The HMIS software package can be used to manage member records of the Community Health Funds. It was

developed under close collaboration with medical directors and other staff members of ELCT hospitals. Hence it is made to operate for ELCT hospitals and at a rural area in East Africa. The diagnostic codes used are based on the WHO ICD system.

Selian Hospital is the first ELCT hospital that tested the HMIS software, and the result is encouraging. It is hoped that the software could significantly reduce a rural hospital's management cost.

The hospital has shown that by using generic drugs as well as conducting treatment and management efficiently, health care can be provided at low cost. This in turn is crucial in allowing the insurance scheme to break even.

Up to November 1998, the insurance scheme provides health coverage to hospital staff only. Eventually, the insurance scheme will be offered to the public too.

Selian Hospital has developed its own organization and management models. It plans to conduct market surveys in order to fine-tuning its health coverage according to the needs of the rural population and to understand further their difficulties in seeking health care.

**-Any bibliographical and written references:**

Debaig, G. (1999) Report on the "Community Based Health Insurance Regional Conference" at Kampala, Uganda, on 9-13 November 1998.

Bennett, S., Creese, A. and Monasch, R. (1998) *Health Insurance Schemes for People Outside Formal Sector Employment*, ARA Paper number 16, Division of Analysis, Research and Assessment, WHO.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

Note: The Evangelical Lutheran Church in Tanzania has 20 church-related hospitals and over 120 community-based health centres and dispensaries all over Tanzania. The ELCT hospitals have a bed capacity of 2,160 and a total of 1,560 employees. The organization contributes to over 13% of total health services in the country. It collaborates closely with the Ministry of Health and is an umbrella organization of the Christian Social Services Commission. At Regional level the ELCT links closely with a Regional Network on Health Financing in Eastern and Southern Africa.

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# V. Tusaidiane Bima Ya Afya Ya Atiman

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Tanzania Episcopal Conference (TEC) Tusaidiane

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   **Address:** TEC Health Department Tusaidiane, P.O.Box 2133, Dar es Salaam, Tanzania.
   **Telephone:** +255-51-5574
   **Email:** msoladartz@maf.org

3. **Contact person:** Sr. Rita Toutant, Missionary Sisters of Our Lady of Africa (MSOLA)

4. **Type of organization responsible for the HMIS:**
   **X** non-profit health care provider: parish

5. **Year (and month) when the scheme was (formally) set up:** 1995

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:**
   1995

7. **Total number of male/female members of the scheme:**

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:**

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** urban area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village

13. **Type of basic health care services covered by the scheme:**
    **X** out-patient care: outpatient consultation
    Note: A contracted health care provider provides health care services

14. **Method of financing the health insurance:**
    **X** members' contributions

15. **Members' participation in the management of the scheme:**
    Information not available

16. **External technical assistance**
    Information not available

17. **Others (if applicable):**
    **-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
    - The community is involved in defining this health insurance system.
    - Through studies, it is found that the expectations of members on the quality of care are increasing over time.
    - The population showed willingness to accept an insurance scheme if it provides quality health care. From experience, in cases when there is a failure in the health care service, members want to change to another health care provider. However, this is almost impossible for Tusaidiane Bima Ya Afya Ya Atiman's members as the insurer is also the health care provider.

    **-Any bibliographical and written references:**
    Debaig, G. (1999) Report on the "Community Based Health Insurance Regional Conference" at Kampala, Uganda, on 9-13 November 1998.

    **-Names of persons and/or organizations that can provide additional information about the scheme:**

# VI. UMASIDA

UMASIDA (which means coming together to take care of our health) was set up at the beginning of 1997 after a finding by INTERDEP of ILO at Dar es Salaam early in 1995 showed that:

- informal sector groups continued to suffer a variety of work related and general health problems
- access to health care services was decreasing rapidly because of increasing medical costs
- worsening quality of care in government health care institutions due to lack of resources
- a cost sharing scheme had been implemented by the government to remedy the situation, but many informal sector workers cannot afford the medical service fees
- private health care services are growing, serving those with capacity to pay

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** UMASIDA

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**

3. **Contact person:**

4. **Type of organization responsible for the HMIS:**
   **X** other community organization: a health insurance organization for the informal sector

5. **Year (and month) when the scheme was (formally) set up:** December 1995

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:**

7. **Total number of male/female members of the scheme:** around 1,300, increased from 1,000 at the beginning

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 6,000 (1998), increased from 4,500 at the beginning

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    **X** more than 50%

11. **Place of residence for the majority of members:**
    **X** urban area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village: Dar es Salaam

13. **Type of basic health care services covered by the scheme:**
    **X** preventive care and health promotion: immunisation
    **X** out-patient care: consultation
    **X** hospital treatment:
    **X** midwife services/ reproductive health care: antenatal clinics, deliveries

**X** others: laboratory tests (the five most regular laboratory tests are: haemoglobin, stool examination for intestinal parasites like hookworm and ascaries, routine urine examination for sugar, albumin, blood and ova, blood slide for malaria parasites and Full Blood Picture examination)

Note: All primary health care services are provided by independent private providers and all secondary, tertiary and preventive health care services are provided by government health care institutions.

**14. Method of financing the health insurance:**

**X** members' contributions: Tsh. 600 per month per household (Tshs 797 = US$1, October 1999). Here, a household is defined as: a member, a spouse and four children

**15. Members' participation in the management of the scheme:**

**X** democratic administration of the scheme by members (general assembly): the scheme is owned by beneficiaries, thus their influence on health care and management is great.

Note: The organization has two committees: the general committee (or UMASIDA board), consisting of all chairpersons and secretaries of the participating groups, and the technical adviser; and the executive committee, consisting of the UMASIDA chairperson, the secretary, the treasurer and technical adviser.

**16. External technical assistance**

**X** receives punctual external technical assistance as required: the scheme was designed and implemented by Institute of Development Studies at Muhimbili, and aided by ILO.

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

UMASIDA was first set up to cover workers from five informal sector associations in Dar-es-Salaam: DASICO Co-operative (Dar es Salaam Small Industries Co-operative Society Ltd), Mwananyamala Market Co-operative, Suma Knife Makers Group, Nasi-Tunajaribu and Mandela Road Stone Crushers Co-operative. In 1998, it was being extended to cover five more informal sector associations.

An evaluation carried out at the beginning of 1998 identified the following areas that need improvement:

- to reinforce the managerial capacities of UMASIDA
- to provide training in mutual health insurance
- to improve the terms of contracts with health care providers
- to enhance transparency and democratic participation
- to revise the UMASIDA constitution

The strength and benefits of the scheme:

- regular evaluations and meetings are carried out by the UMASIDA board and executive committee
- large savings from the scheme have remained in the account for the use of beneficiaries
- the scheme is owned by beneficiaries, hence maximising members' participation
- because UMASIDA gives contractual priority to private health care providers that offer vaccines and maternity care, other health care providers that are not under UMASIDA's contract started to offer these services to their clients

- financial losses of government hospitals have been minimised as payments of health care services provided to insured patients are directly reimbursed through banking transaction
- quality of care has been improved through close monitoring of private health care provision and the competitive effect among health care providers.

The two largest groups, DASICO Co-operative and Mwananyamala Market Co-operative, managed to set up a drug dispensary and sign contracts with local health care providers, facilitating better access to health care for their members. However, the three smaller groups have difficulties to keep up regular contribution to UMASIDA scheme.

DASICO Co-operative, with some 1,000 workers, set up its own enterprise clinic. The clinic has been successful in reducing the cost of primary health care substantially for its beneficiaries as well as in reducing accidents and work-related illnesses by holding health education seminars for its members.

DASICO Co-operative also offers death benefits to its members. In the event that a member dies, DASICO will grant Tsh 10,000 to the bereaved family. Tsh 5,000 will be granted to the death of a member's relative. In addition, some of the departments within the co-operative have separate insurance benefits for their workers, for example metal workers give Tsh 50,000 to a member's funeral. Some of them also give loans to members for specific purposes.

Preparations have also been made by ILO to replicate this health insurance scheme elsewhere in the United Republic of Tanzania, Benin, El Salvador and India.

### -Any bibliographical and written references:

Kiwara, A.D. (1998) *UMASIDA Health Insurance Scheme in Tanzania: Basic Information*, Institute of Development Studies at Muhimbili, Dar es Salaam, Tanzania.

Kiwara, A.D. (1997) *UMASIDA Backup Report*, Tanzania.

Dr. Atim, C. (1997) *WSM Mutuals' Identification Mission to: Ethiopia, Tanzania, Zimbabwe, South Africa.*

http://www.ilo.org/public/english/poverty/projects/1998/umasida.htm

http://www-ilo-mirror.who.or.jp/public/english/…c86/repi-c3.htm

**-Names of persons and/or organizations that can provide additional information about the scheme:**

# Togo


I. Affaires Sociales USYNCOSTO (Union Syndicale des Coiffeuses de style du Togo)

II. Association des Sages Femmes du Togo

III. Djagbagba

IV. MU-CO-TA-S-GA (Mutuelle des Conducteurs de Taxi Motos de la station Gaitou)

V. MUSA – CSTT (Mutuelle de Santé – CSTT)

VI. MUSAD (Mutuelle de Santé ADIDOADE)

VII. Mutuelle OTP (Office Togolais des Phosphates)


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## I. Affaires Sociales USYNCOSTO (Union Syndicale des Coiffeuses de style du Togo)

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** s/c de la présidente de l'USYNCOSTO
   ***Telephone:*** +228-25 36 82

3. **Contact person:**
   Madam DOGBO, President

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up:** September 1996

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** September 1996

7. **Total number of male/ female members of the scheme:** 37

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 37 (Target population: all hairdresser who are members of USYNCOSTO)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**

Information not available

**11. Place of residence for the majority of members:**

**X** urban area

**12. Geographical area covered by the health micro-insurance scheme:**

**X** national

**13. Type of basic health care services covered by the scheme:**

**X** hospital treatment: all benefits related to hospitalisation are paid a lump-sum of 5,000 CFA Franc

Note: In 1998, it was planned that the lump-sum payment for hospitalisation will be increased to 10,000 CFA Franc, and expenses for child birth delivery will be reimbursed up to 6,000 CFA Franc.

**14. Method of financing the health insurance:**

**X** members' contributions: Membership fee is 500 CFA Franc; monthly premium for an individual is 500 CFA Franc, and the family is not covered.

**15. Members' participation in the management of the scheme:**

**X** democratic administration of the scheme by members (general assembly): The mutual is administered by a provisional office (General Assembly) comprised of 37 subscribers. It does not have an office and 5 permanent volunteers are in charge of daily management.

**16. External technical assistance**

Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

The members of this mutual are sustained by the relatively strong ties and solidarity among themselves. There is a mixed opinion on the quality of the mutual's management. The activities of the mutual are not held separately from that of the trade union. Thus, during the general assembly, premiums are being collected.

**-Any bibliographical and written references:**

Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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## II. Association des Sages Femmes du Togo (Midwife Association of Togo)

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** s/c ENSF, BP 1271
   ***Telephone:*** +228-21 46 70, 16 15 19

3. **Contact person:**
   Adjoua MIVEDOR, President
   Mery BARRY, Manager

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up:** 1966, renewed in June 1996

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:**
   January 1997

7. **Total number of male/ female members of the scheme:** 430

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 430 (Target population: all midwives of Togo with nationality Togolaise, between 700 to 800 people)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** rural area
    **X** urban area
    **X** urban surroundings

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** national

13. **Type of basic health care services covered by the scheme:**
    **X** hospital treatment: all benefits related to hospitalisation is given a lump-sum between 50,000 CFA Franc and 150,000 CFA Franc according to the seriousness of the case.

14. **Method of financing the health insurance:**
    **X** members' contributions: Membership fee is 1,000 CFA Franc; monthly premium is 500 CFA Franc per subscriber (the family is not covered)
    **X** non-state subsidies from development agencies, donors etc.: Subsidies provided by World Bank and World Health Organization
    **X** others: UNICEF provides training

15. **Members' participation in the management of the scheme:**
    **X** democratic administration of the scheme by members (general assembly): General assembly, the governing body, the control committee meet frequently. The mutual does not have an office and is managed by 11 temporary volunteers.

**16. External technical assistance**
Information not available

**17. Others (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
This mutual offers good benefits package for hospitalisation, but it experiences difficulties in management and in premium collection. When the research on this association was carried out, it has just started its health insurance operation, hence the spirit of mutuality was not yet fully appreciated by the members. The mutual plans to set up its own health facility.

**-Any bibliographical and written references:**
Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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# III. Djagbagba

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**
***Address:*** KOUVE
***Telephone:*** s/c +228-36 90 05

**3. Contact person:**
Kossi MOEVI, Manager
Yao Gbedegbebou, Manager

**4. Type of organization responsible for the HMIS:**
**X** mutual benefit society

**5. Year (and month) when the scheme was (formally) set up:** December 1996

**6. Year (and month) when the scheme began to deliver the first benefits to beneficiaries:**
April 1997

**7. Total number of male/ female members of the scheme:** 40

**8. Total number of members in the organization that has set up the scheme:**

**9. Total number of current male/ female beneficiaries of the scheme:** 160 (Target population: all inhabitants of Kouve, around 22,000)

**10. Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
Information not available

**11. Place of residence for the majority of members:**

**X** rural area

**12. Geographical area covered by the health micro-insurance scheme:**

**X** department

**13. Type of basic health care services covered by the scheme:**

**X** hospital treatment: hospitalisation: a lump-sum of 10,000 CFA Franc and donation in kind

**X** midwife services/ reproductive health care: delivery: a lump-sum of 8,000 CFA Franc and donation in kind

**X** others: a supplementary help of 25,000 CFA Franc may be granted to buy medicines in exceptional cases (often at the time of a surgical intervention)

**14. Method of financing the health insurance:**

**X** members' contributions: membership fees of 500 CFA Franc for men and 300 CFA Franc for women; monthly premium of 500 CFA Franc per family for male subscriber and 300 CFA Franc for women subscriber. Family members are: the subscriber, the spouse(s), the children and direct ascendants.

**15. Members' participation in the management of the scheme:**

**X** democratic administration of the scheme by members (general assembly): General assembly and the control committee meet frequently. The mutual has an office and is managed by 11 temporary volunteers.

**16. External technical assistance**

Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

At the time of the research, this mutual has only been in operation for 8 months. The youth and dynamism of its members are assets to the mutual association. Nevertheless, the lack of training on the part of the managers on insurance management and irregular income of peasants poses a threat to the mutual.

**-Any bibliographical and written references:**

Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

# IV. MU-CO-TA-S-GA (Mutuelle des Conducteurs de Taxi Motos de la Station Gaitou) (Taxi drivers of Gaitou Station Mutual)

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** BP 60 544, LOME
   ***Telephone:*** s/c +228-22 11 17

3. **Contact person:**
   Emmanuel AGBENOU, President

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up:** July 1997

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:**
   Was expected to start in January 1998

7. **Total number of male/ female members of the scheme:** 57

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 57 (Target population: all drivers or sympathiser of taxi-moto, with around 3,000 persons)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** urban area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village

13. **Type of basic health care services covered by the scheme:**
    **X** hospital treatment: all benefits related to hospitalisation is paid a lump-sum of 20,000 CFA Franc
    **X** midwife services/ reproductive health care: delivery is paid a lump-sum of 25,000 CFA Franc

14. **Method of financing the health insurance:**
    **X** members' contributions: membership fee is 2,000 CFA Franc; weekly individual premium is 100 CFA Franc, and the family is not covered.

15. **Members' participation in the management of the scheme:**

**X** democratic administration of the scheme by members (general assembly): general assembly and executive office meet regularly. The mutual does not have an office and is managed by 7 temporary volunteers.

**16. External technical assistance**
Information not available

**17. Others (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
This mutual was created by unemployed young graduates who had the will and dynamism. The taxi-moto drivers have established very strong ties and solidarity among themselves. However, the mutual has experienced difficulties in recruting subscribers. The mutual has to take precaution because taxi-moto drivers constitute a high-risk group, considering they are exposed to accidents on the road everyday.

**-Any bibliographical and written references:**
Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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# V. MUSA – CSTT (Mutuelle de Santé – CSTT)

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**
***Address:*** BP 3058, LOME
***Telephone:*** +228-22 11 17

**3. Contact person:**
Komivi Agbogzi EDAH, General Secretary

**4. Type of organization responsible for the HMIS:**
**X** mutual benefit society

**5. Year (and month) when the scheme was (formally) set up:** May 1997

**6. Year (and month) when the scheme began to deliver the first benefits to beneficiaries:**
Was expected to start in January 1998

**7. Total number of male/ female members of the scheme:** Not known, still recruiting

**8. Total number of members in the organization that has set up the scheme:**

**9. Total number of current male/ female beneficiaries of the scheme:** Same as above (Target population: all members of the 30 trade unions under CSTT)

**10. Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
Information not available

**11. Place of residence for the majority of members:**
- **X** rural area
- **X** urban area
- **X** urban surroundings

**12. Geographical area covered by the health micro-insurance scheme:**
- **X** national

**13. Type of basic health care services covered by the scheme:**
- **X** medicines: 30% on prescriptions over 5,000 CFA Franc; 50% on prescriptions less than 5,000 CFA Franc. The insured members have to buy medicine at the shop belongs to mutual to get reimbursement.

**14. Method of financing the health insurance:**
- **X** members' contributions: membership fee is 2,000 CFA Franc; monthly premium for a family is 1,500 CFA Franc. Family members are: the subscriber, the spouse and 4 children.
- **X** others: a starting fund of 5,000 CFA Franc is contributed by a trade union. CSTT helps to provide material like offices, office materials etc.

**15. Members' participation in the management of the scheme:**
- **X** democratic administration of the scheme by members (general assembly): General assembly, the governing body, office and control committee meet frequently. The mutual has an office and is managed by 7 permanent volunteers.

**16. External technical assistance**
Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

This mutual has not started its operations but already has experienced difficulties in recruiting subscribers and collecting premiums.

Aggravating the situation even more is the fact that certain members of trade unions do not understand the usefulness of health mutual although the mutual was set up after the training session organised by CSTT at the early part of 1997. Considering the situation, a lot of awareness-raising campaign has to be made.

**-Any bibliographical and written references:**

Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

# VI. MUSAD (Mutuelle de Santé ADIDOADE)

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** BP 62 210, LOME
   ***Telephone:*** +228-25 97 73, 21 20 65
   ***Fax:*** +228-21 47 30

3. **Contact person:**
   **Name:** Michel Taylor, Pesident
   **Name:** Mariane AKAKPO, Manager

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up:** September 1997

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:**
   Was expected to start in April 1998

7. **Total number of male/ female members of the scheme:** An awareness-raising compaign is being carried out and it was expected to recruit around 300 members

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** same as above (Target population: all parents who were students and have children at LE JOURDAIN school and college, as well as interested residents of ADIDOADE area)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** urban area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village

13. **Type of basic health care services covered by the scheme:**
    **X** outpatient care: consultations are free for the students whom their parents are subscribers and 300 CFA Franc for the sunscribing parents.
    **X** medicines: no detail.
    Note: Consultations have to take place at the health centre affiliated with the health scheme, which is located in the area.

14. **Method of financing the health insurance:**

X members' contributions: membership fee is 2,000 CFA Franc and monthly premium for a family is 1,500 CFA Franc. Family members are: the subscriber, a spouse and school-age children.

**15. Members' participation in the management of the scheme:**

X democratic administration of the scheme by members (general assembly): General assembly, the governing body and the office meet frequently. The mutual has an office and is managed by 2 permanent and 5 temporary volunteers.

**16. External technical assistance**

Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

It is still too early to evaluate this mutual but it seems to have a promising future.

**-Any bibliographical and written references:**

Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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## VII. Mutuelle OTP (Office Togolais des Phosphates)

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**
***Address:*** OTP, KPEME BP 362 LOME, Togo
***Telephone:*** +228-21 39 01

**3. Contact person:**

**4. Type of organization responsible for the HMIS:**

X mutual benefit society

**5. Year (and month) when the scheme was (formally) set up:** April 1988

**6. Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** April 1988

**7. Total number of male/ female members of the scheme:** 2,400

**8. Total number of members in the organization that has set up the scheme:**

**9. Total number of current male/ female beneficiaries of the scheme:** Around 12,000 (Target population: all permanent agents of OTP)

**10. Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
Information not available

**11. Place of residence for the majority of members:**
**X** urban area

**12. Geographical area covered by the health micro-insurance scheme:**
**X** national

**13. Type of basic health care services covered by the scheme:**
**X** outpatient care: consultation 100%
**X** hospital treatment: all health service related to hospitalisation 100%
**X** midwife services/ reproductive health care: delivery 100%
**X** medicines 50%

**14. Method of financing the health insurance:**
**X** members' contributions: Monthly premium for a family could be 1,200 CFA Franc, 2,500 CFA Franc and 4,000 CFA Franc, depends on the category. Family members are: the subscriber, spouse(s) (limited to three) and the children (limited to 6)
**X** others: Subsidy from the company
Note: premiums are deducted from source automatically.

**15. Members' participation in the management of the scheme:**
**X** administration by the organization responsible for the administration of the HMIS without members' participation other than choice of health services covered. The mutual is not managed democratically. Its operation is entrusted to the company through middleman. The chief of the medical-social makes all the decisions. However, there is a control committee. The mutual has offices from the company and is managed by 7 employees of OTP, permanently detached, as far as the mutual is concerned.

**16. External technical assistance**
Information not available

**17. Others (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
The range of benefits offered by this mutual is relevant to the needs of its members, but the mutual is experiencing the following difficulties:

- Management interference from the company. As a result, a new policy was drafted to entrust the management to the insured members.
- Excessive debt. The mutual is worried over this problem.
- Over consumption of benefits

The mutual continues to operate thanks to the financial support of the company. However, the whole organizational structure has to be reviewed in order to entrust its members the responsibilities and control in the use of benefits.

**-Any bibliographical and written references:**

Massiot, N. (1998) *Inventaire des mutuelles de santé*, a study carried out by *ILO/STEP, ILO/ACOPAM, USAID/PHR*, *ANMC, WSM.* Draft paper.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

# Uganda

I. Ishaka Hospital Health Insurance Scheme
II. Kisiizi Hospital Health Insurance Scheme
III. Kisoro District and Kampala's Hospital Health Insurance Scheme
IV. Kiwoko Hospital Community-based Health Insurance, Luweero district
V. Nsambya Hospital Health Plan

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## I. Ishaka Hospital Health Insurance Scheme

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Ishaka Hospital

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
**Address (state country):** Ishaka Hospital, P.O.Box 111, Bushenyi, Uganda
**Telephone:** +256-485-42016
**Email:** ishahosp@infocom.co.ug
**Fax:** +256-485-42755

3. **Contact person:** Ms. I. van Hoff, Mr. J. Tumusiime

4. **Type of organization responsible for the HMIS:**
**X** non-profit health care provider: this missionary hospital belongs to Seventh Day Adventists

5. **Year (and month) when the scheme was (formally) set up:** 1999

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 1999

7. **Total number of male/female members of the scheme:** unknown

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** unknown (Target population: Dairy co-operatives, rural communities within the catchment area of Ishaka Hospital and schools)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
Information not available

**11. Place of residence for the majority of members:**
**X** rural area

**12. Geographical area covered by the health micro-insurance scheme:**
**X** commune/village

**13. Type of basic health care services covered by the scheme:**
**X** out-patient care
**X** hospital treatment

**14. Method of financing the health insurance:**
**X** members' contributions: US$18 for a family of four per year
**X** state contribution: The Ministry of Health will cover the deficits incurred from the running cost for the first three years of operation.

**15. Members' participation in the management of the scheme:**
Note: Ishaka Hospital's Health Insurance Scheme is based on the Kisiizi Hospital's model. Risk and general management of the scheme is totally the responsibility of the hospital.

**16. Technical assistance**
**X** receives regularly external technical assistance: The hospital receives technical assistance from the Ministry of Health, DISH, Health Partners, Department for International Development (DFID, UK)

**17. Other (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
Studies implemented indicate difficulties in mobilising the local population for an insurance system due to a relatively poor perception of the Hospital.

**-Any bibliographical and written references:**
Debaig, G. (1999) Report on the "Community Based Health Insurance Regional Conference" at Kampala, Uganda, on 9-13 November 1998.

**-Names of persons and/or organizations that can provide additional information about the scheme:**
Dr. Joy Batusa, Health Partners c/o DISH Project.

Email: ribtsa@infocom.co.ug

Tel: +256-41-34 23 53

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# II. Kisiizi Hospital Health Insurance Scheme

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** CoU Kisiizi Hospital

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**
**Address (state country):** P.O.Box 109, Kabale, Uganda

3. **Contact person:** Mr. M. Mugume, Dr. Peter Wood/Dr. Lionel Mills (Medical Superintendent)

4. **Type of organization responsible for the HMIS:**
   **X** non-profit health care provider: this missionary hospital is owned by Church of Uganda

5. **Year (and month) when the scheme was (formally) set up:** 1996

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 1996

7. **Total number of male/female members of the scheme:**

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:**

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** rural area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village

13. **Type of basic health care services covered by the scheme:**
    **X** out-patient care: outpatient consultation
    **X** hospital treatment
    Note: the health care service coverage is decided by the doctors on the basis of public health criteria.

14. **Method of financing the health insurance:**
    **X** members' contributions: US$35 per family of four per year (1998)

15. **Members' participation in the management of the scheme:**
    Information not available

16. **Technical assistance**
    Information not available

17. **Other (if applicable):**
    **-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
    Strength:

    - Communities are involved in defining the health insurance system
    - Health insurance memberships are only granted only when at least 60% of the members of traditional groups (Engozo) subscribe as a group. So risk can be spread over a wider base.

This health insurance scheme is not subjected to the problem of over-consumption of outpatient care. One of the reason could be the difficulty in reaching the hospital for geographical reasons.

**-Any bibliographical and written references:**

Creese, A. and Bennett, S. (1997) *Rural Risk-Sharing Strategies* in "Innovations in Health Care Financing", a World Bank Discussion Paper No. 365, edited by Schieber, G.J., p.163-182.

Bennett, S., Creese, A. and Monasch, R. (1998*) Health Insurance Schemes for People Outside Formal Sector Employment*, ARA Paper number 16, Division of Analysis, Research and Assessment of World Health Organization.

Debaig, G. (1999) Report on the "Community Based Health Insurance Regional Conference" at Kampala, Uganda, on 9-13 November 1998.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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# III. Kisoro District and Kampala's Hospital Health Insurance Scheme

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** THE HIGHWAY OF HOLINESS EVANGELICAL INTERNATIONAL

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   **Address (state country):**
   **Telephone:**
   **Email:**
   **Fax:**

3. **Contact person:** Mr. A. Mastiko, ILO/Mutual Health Care Protection

4. **Type of organization responsible for the HMIS:**
   **X** other: religious organization

5. **Year (and month) when the scheme was (formally) set up:**

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:**

7. **Total number of male/female members of the scheme:**

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:**

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**

Information not available

**12. Geographical area covered by the health micro-insurance scheme:**
Information not available

**13. Type of basic health care services covered by the scheme:**
**X** out-patient care
**X** hospital treatment

**14. Method of financing the health insurance:**
**X** members' contributions: premium is estimated to be US$8 for a family of four per year.

**15. Members' participation in the management of the scheme:**
Note: it is a hospital-based health insurance scheme, modeled after Kisiizi Hospital Health Society. Risk and general management is the responsibility of the hospital.

**16. Technical assistance**
**X** receives regularly external technical assistance: it receives technical assistance from Mutual Health Care Protection of ILO

**17. Other (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

**-Any bibliographical and written references:**
Debaig, G. (1999) Report on the "Community Based Health Insurance Regional Conference" at Kampala, Uganda, on 9-13 November 1998.

**-Names of persons and/or organizations that can provide additional information about the scheme:**
Mr. A. Mastiko, ILO/Mutual Health Care Protection, P.O.Box 25516, Kampala, Uganda.

Tel: +256-75-69 65 22

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## IV. Kiwoko Hospital Community-based Health Insurance, Luweero district

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** CoU Kiwoko Hospital

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**
**Address (state country):** CoU Kiwoko Hospital, P.O.Box 149, Luweero, Uganda
**Telephone:** +256-41-610 132
**Email:** ---
**Fax:** +256-41-610 132

**3. Contact person:** Dr. Nick Wooding

**4. Type of organization responsible for the HMIS:**

X non-profit health care provider: this missionary hospital belongs to the Church of Uganda

5. **Year (and month) when the scheme was (formally) set up:** 13 May 1999

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 13 May 1999

7. **Total number of male/female members of the scheme:** unknown

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** unknown (Target population: rural population in the catchment area of Kiwoko Hospital)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    X rural area

12. **Geographical area covered by the health micro-insurance scheme:**
    X commune/village

13. **Type of basic health care services covered by the scheme:**
    X out-patient care
    X hospital treatment
    X midwife services/ reproductive health care
    X medical evacuations
    Note: At first, Kiwoko Hospital will establish a health savings system. Gradually it will progress towards a health insurance system covering outpatient and inpatient emergencies, transport costs and complications of childbirth.

14. **Method of financing the health insurance:**
    X members' contributions: insurance premium will be US$18 for a family of six per year.

15. **Members' participation in the management of the scheme:**
    X democratic administration of the scheme by members (general assembly): It is a self-managed pre-payment system belongs to the beneficiaries.

16. **Technical assistance**
    X receives regularly external technical assistance: it receives external assistance from CIDR (Centre Internationale de Developpement et de Recherche).

17. **Other (if applicable):**
    **-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
    A study that was carried out before launching the insurance scheme found local people's perception of the quality of care is paramount. Population in Luweero expressed a

preference for missionary hospitals over government health services. They have more confidence on the quality of care provided by missionary hospitals, in addition to better reception, availability of drugs and personnel.

Study in Luweero found that hospitalisation coverage is a priority for both men and women. It then follows by transportation costs, outpatient care and childbirth.

In Luweero, financial difficulties and irregular income are often related to the agricultural year. There is a lack of solidarity between the people, hence they favour sale of goods as a strategy to finance extra health expenditure over mutual aid.

**-Any bibliographical and written references:**

Debaig, G. (1999) Report on the "Community Based Health Insurance Regional Conference" at Kampala, Uganda, on 9-13 November 1998.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

Mr. Guillaume Debaig, CIDR, P1, 60350 Autrecmes, France

Email: cidr@compuserve.com

Tel: +33-344-92 71 40

Fax: +33-344-42 94 52

Ms. E. Yard, CIDR, P.O.Box 149, Luweero, Uganda

Fax: +256-41-610 132

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# V. Nsambya Hospital Health Plan

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Nsambya Hospital

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   **Address (state country):** Nsambya Hospital, Health Plan, Kampala, Uganda
   **Telephone:** +256-41-267 377
   **Email:** nhhp@infocom.co.ug
   **Fax:** +256-41-267 377

3. **Contact person:** Dr. Gerry Noble, Mrs. Babara Ssamula

   **Address (state country):** Dr. Joy Batusa, Health Partners c/o DISH Project
   **Telephone:** +256-41-342 353
   **Email:** ribtsa@infocom.co.ug
   **Fax:** ---

4. **Type of organization responsible for the HMIS:**
   **X** non-profit health care provider: This is a missionary hospital

5. **Year (and month) when the scheme was (formally) set up:** 1999

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 1999

7. **Total number of male/female members of the scheme:** expected to cover a limited number of groups during the first year

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** unknown (Target group: there are four main groups, hospital personnel, salaried workers of private enterprise, boarding facilities, low-income groups)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    - **X** urban area: Nsambya Hospital situates at Kampala, the capital city of Uganda
    - **X** urban surrounding

12. **Geographical area covered by the health micro-insurance scheme:**
    - **X** commune/village: city-wide

13. **Type of basic health care services covered by the scheme:**
    - **X** out-patient care
    - **X** hospital treatment

    Note: Plan 1 covers outpatient and inpatient care. Plan 2 covers inpatient care only. The waiting period is two weeks.

14. **Method of financing the health insurance:**
    - **X** members' contributions: Plan 1 is US$39 for a family of four per year. Plan 2 is US$13 for a family of four per year. Co-payment is US$1 for outpatient consultation and US$3 for hospitalisation.
    - **X** state contribution: Ministry of Health will cover deficits incurred on the operational cost of the insurance scheme during the first year.

15. **Members' participation in the management of the scheme:**
    Note: this is a hospital managed insurance scheme.

16. **Technical assistance**
    Information not available

17. **Other (if applicable):**
    **-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

**-Any bibliographical and written references:**

Debaig, G. (1999) Report on the "Community Based Health Insurance Regional Conference" at Kampala, Uganda, on 9-13 November 1998.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

# Asia

# Bangladesh

I. Community insurance scheme under Gonoshasthya Kendra Health Care System in Savar

II. Health Card Programme of Dhaka Community Hospital

III. Institute of Integrated Rural Development (IIRD) health insurance scheme

IV. Rural Health Programme of Grameen Kalyan

V. Proposed health insurance from Proshika health programme

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## I. Gonoshasthaya Kendra Health Care System's Community insurance scheme, Savar

Gonoshasthaya Kendra Health Care System's Community insurance scheme is implemented in eleven areas in total, ten of them are in rural areas and one in urban area.

| Name of the project | Location (district) | Set up in year |
|---|---|---|
| Savar Gonoshasthaya Kendra | Savar | 1975 |
| Bhatsala Gonoshasthaya Kendra | Sherpur | 1976 |
| Sreepur Gonoshasthaya Kendra | Gazipur | 1980 |
| Saturia Gonoshasthaya Kendra | Manikgonj | 1983 |
| Serajgonj Gonoshasthaya Kendra | Serajgonj | 1984 |
| Shibgonj Gonoshasthaya Kendra | Chapai Nawabgonj | 1985 |
| Sonagazi Gonoshasthaya Kendra | Feni | 1985 |
| Kashinathpur Gonoshasthaya Kendra | Pabna | 1987 |
| Cox's Bazar Gonoshasthaya Kendra | Cox's Bazar | 1991 |
| Charfesson Gonoshasthaya Kendra | Bhola | 1991 |
| Dhaka Urban Gonoshasthaya Kendra | Dhaka | 1993 |

The following description is only on Savar project Area.

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Gonoshasthya Kendra (GK)

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   **Address:** Gonoshasthaya Kendra, Savar, Dhaka 1344, Bangladesh
   **Telephone:** +880-2-7708 335/ 7708 336/ 500 720/ 861 7208
   **Email:** gksavar@citechco.net/ gk@citechco.net/ pha_gk@citechco.net
   **Fax:** +880-2-7708 336/ 861 3567/ 861 6719

3. **Contact person**: Dr. Qashem Chowdhury, Executive Director; Dr. Zafrullah Chowdhury, Project Coordinator

4. **Type of organization responsible for the HMIS:**
   **X** others: NGO

5. **Year (and month) when the scheme was (formally) set up:** 1975

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 1975

7 **Total number of male/female members of the scheme:** about 12,567 families are currently insured with the Savar community insurance scheme (figure in year 2000). In total, 25,846 families are members of all eleven community insurance schemes. (figure in year 2000)

7. **Total number of members in the organization that has set up the scheme:**
   Note: GK initiated the insurance scheme in collaboration with the members of the community

9. **Total number of current male/ female beneficiaries of the scheme:** about 12,567 families (2000) (Target population: all 43,356 families in the catchment area of Savar, with a total 155,000 – 190,000 inhabitants are eligible to register with insurance scheme (source: GK, 2000))
   Note: Total number of families who are considered as target population in all eleven catchment areas is 144,661 (figure in year 2000).

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** rural area: in 13 Thanas of 11 districts
    Note: Bangladesh have altogether 490 Thanas.

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** department/ district: subdistrict

13. **Type of basic health care services covered by the scheme:**
    **X** preventive care and health promotion: free, and free family planning
    **X** out-patient care: consultation costs Taka 5-20

**X** hospital treatment

**X** midwife services/ reproductive health care: Taka 50-5,000 based on socio-economic status

**X** medicines: 0-75% discounts based on socio-economic status

**X** others: Reimbursements for referrals to specialists follow a sliding ratio

Note: there is a two-week waiting period.

**14. Method of financing the health insurance:**

**X** members' contributions: voluntary

**X** non-state subsidies from development agencies, donors etc.

**X** others: profits made from business ventures (printing, essential drugs and raw materials production and marketing, textile production) are used to subsidise health care provision and other development activities.

Note: the premiums members pay are based on their socio-economic groups, which are classified into five groups: (Desmet and Chowdhury, 1997)

Group O: Destitute and single-headed households, mostly widowed or divorced women as well as disabled people.

Group A: Households that cannot afford two meals a day for all its members; landless farmers or farmers with less than 1 acre of land; daily wage earner; all other households with no regular income.

Group B: Households that meet the minimum needs of its members, but have no savings such as farmers with small land-holding of 2-3 acres of land in total, small shop owners, and industry labour workers.

Group C: Households with savings such as farmers with more than 3 acres of land; owners of big shops or business; middle and upper class civil servants and professionals.

| Groups | O | A | B | C | Non-insured |
|---|---|---|---|---|---|
| Premium | 7 | 25 | 50 | 75 | |
| Renewal fee | 5 | 15 | 35 | 50 | |
| Consultation fee | 5 | 10 | 12 | 20 | 25 |
| Drugs | free | Pay 25% | Pay 75% | Full price | Full price |

Source: GK, 2000

Note: The premium and grouping of the membership of Dhaka Urban Gonoshasthaya Kendra is different from the rural programmes.

**15. Members' participation in the management of the scheme:**

**X** administration by the organization responsible for the administration of the HMIS without members' participation other than choice of health services covered.

**16. External technical assistance**

**X** does not receive external technical assistance

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

Gonoshasthaya Kendra (GK) started as a health project in 1971 with donor support and gradually expanded into a two-tier health care provider with a 70-bed hospital and 4 sub-centres. The area of operation of the organization spreads over 164 villages of 2 thanas of Dhaka and Gazipur districts. Its objective in setting up a community insurance scheme is to allow the poor greater access to health care. The programme is now replicated in ten different locations of Bangladesh including one in urban area.

GK is involved in a variety of community development projects, and many of these projects are women focused. It ranges from health services and training, education for children of the poor family, vocational training for women, agriculture and fisheries, rural credit, publication and vaccine research.

GK is the pioneer organization to stand by the side of the poor during any national disaster. For the last two years, GK started community-based education for the medical, dental, pharmacy, microbiology and physiotherapy students. The businesses it involves in not only complements its development projects, they are sources of revenue. At the same time, their quality medical products are real alternatives to consumers at affordable prices.

Gonoshasthaya Kendra(GK) insurance scheme is for 100% families of its catchment area, nobody is excluded. Membership is voluntary. Registration and premium are in sliding scales according to socio-economic status of the family. GK provides preventive and promotive care including immunisation, family planning, mother and child care to 100% population in its catchment area free of charge. Insurance scheme provides the cost of curative care. Non-insured families can also get the curative care with higher cost. More than 80% of the destitute in the coverage area of GK join the insurance scheme, reflecting the scheme's capability in reaching the poorest of the poor.

From the experience of GK, they found that even small premium is not that small for the poor. This is why they believe that sectoral integration like poverty alleviation programme with health intervention is crucial for a developing country like Bangladesh.

### -Any bibliographical and written references:

Chao, S. (1998) "Community Health Insurance in Bangladesh, A Viable Option?", draft paper.

Kech, S. and Wagner, O. (1998) "Health Insurance linked to Community-Financing", STEP/ILO publication.

Desmet, M., Chowdhury, A. Q., Islam, K. (1999) "The potential for social mobilisation in Bangladesh: the organization and functioning of two health insurance schemes."

**-Names of persons and/or organizations that can provide additional information about the scheme:**

# II. Health Card Programme of Dhaka Community Hospital

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Dhaka Urban Community Health Programme (DUCHP)

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   **Address:** 1089 Malibagh Choudhurypara, Dhaka-1219, Bangladesh.
   **Telephone:** +880-2-834 887 or 416 582
   **Email:** dch@bangla.net
   **Fax:** +880-2-833 385
   **Web site:** http://bicn.com/dch/

3. **Contact person:**

4. **Type of organization responsible for the HMIS:**
   **X** others: NGO

5. **Year (and month) when the scheme was (formally) set up:** 1988-89

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:**

7. **Total number of male/female members of the scheme:** 38,000-57000 families

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** (Immediate target population: 6 million users of the medical facilities in 17 areas)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** rural area
    **X** urban area
    **X** urban surroundings
    Note: it is operated in 17 areas

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** province/region

13. **Type of basic health care services covered by the scheme:**
    **X** preventive care and health promotion: education
    **X** out-patient care: consultation cost is Tk10 for some card holders and Tk15 for non-card holders.
    **X** hospital treatment: a new type of health card is provided to some companies in urban area to cover in-patient care.
    **X** others: pathological test is free for only 3 simple tests

Note: referrals for specialist consultation, medical test and hospitalisation at Dhaka Community Hospital are charged at their regular prices. Medicines are sold at market price too.

Typical fees for hospital-based service would be the following (1999)

- medical officer consultation costs Tk 15 or Tk 10 for cardholders
- specialist consultation costs Tk 20-30
- hospital bed per day, general ward Tk 50, semi-private Tk 250, private Tk 350, with air conditioning Tk 800
- total costs for major surgery, Tk 6000-10,000 (typical costs in commercial hospital would be Tk 20,000-30,000).

**14. Method of financing the health insurance:**

**X** members' contributions

**X** state contribution: land

Note: there are 5 types of health insurance package (or health cards)

- ***Family Health Card:*** Issued by rural clinics to rural households with a maximum of 12 family members, including servants living in the household, for Tk 5-20 per month. Cardholders can consult the clinic doctor at any time and have weekly home visits by a family health visitor.
- ***School Children Card:*** Issued to school children for Tk 5 per month. A DCH doctor visits them twice monthly and a group of specialists visit them twice a year at school. Growth is monitored, an annual health check-up is conducted, and health education lessons are given.
- ***Worker Health Card:*** Issued to industrial workers for Tk 5-20 per month. A DCH doctor visits the industrial health clinics weekly and an annual health check-up is conducted. Premiums are paid by the companies or the Owners Associations.
- ***Sport Card:*** Issued to professional sport players for free, mainly for publicity. Free medical consultation is provided.
- ***Destitute Card:*** Issued to selected poor families for free. It allows the poor households to visit the clinic at Tk5 per visit. The Community Committees decide which families in the village entitle to the destitute card.

**15. Members' participation in the management of the scheme:**

**X** members' involvement in the organization responsible for the administration of the health micro-insurance scheme

**16. External technical assistance**

**X** does not receive external technical assistance

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

Drawbacks of the insurance scheme from the users' point of view:

- In-patient care is not covered, and it is specifically this type of care that they have difficulty to pay for. This is one of the reasons for non-renewal of the health card.
- Some households feel that they can afford to pay Tk10 for consultation even without subscribing to the health card.

- Most rural clinics under the Dhaka Community Hospital (DCH) were not equipped to perform pathological tests and to conduct medical examinations such as X-rays. In addition DCH is usually inaccessible and too expensive to go to for many rural members.

Advantages and benefits of the scheme:

Greater access to primary health care. There are 12 rural health clinics in eight districts, 24 industrial health clinics on company premises in Dhaka, and 12 school health clinics for underprivileged and working children. Rural clinics provide primary and secondary health care services, and a DCH specialist visits them every month to provide specialist care. These clinics provide medical services that are close to their insured members.

**-Any bibliographical and written references:**

Chao, S. (1998) "Community Health Insurance in Bangladesh, A Viable Option?", draft paper.

Kech, S. and Wagner, O. (1998) "Health Insurance linked to Community-Financing", STEP/ILO publication.

http://bicn.com/dch/

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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## III. Institute of Integrated Rural Development (IIRD) health insurance scheme

The Institute of Integrated Rural Development (IIRD) was set up in 1987 as an NGO, to develop a model of integrated rural development programme. It has many projects in Bangladesh, most of which are focused on expanding opportunities for women in the society. Through its programmes, women learn both vocational and financial management skills and begin to take a more active role in the society.

IIRD has recently initiated a two-year health project, entitled "Basic education and primary health care programme" which targets the poorest people living in Kachua Thana, a rural area, in the Chandpur District. These people suffer from poor health, malnutrition, with limited access to health facilities and functional education. This target group is around 12,800 families, out of the total local population of 39,300 families.

These very poor families do not owned any asset or land, or they are marginal farmers and small farmers with less than one acre of land, or they earn less than Taka 445 (US$9) per month.

IIRD is expecting to set up a health insurance scheme by mid-2001 to help the poor to access to healthcare. It is estimated that with an insurance premium of Tk60-100 per family per year, the mother and children are entitled to preventive and health promotion services like children weighing, nutrition supplementation, nutritional and health education.

The premium will cover 25-30% of the total cost of the scheme. 10% of service charge for curative care like medicine will be imposed two years after the initial start, and would cover another 20% of the total cost. The Village Development Fund, which is set up by IIRD from the earnings of income generating programme, will contribute another 10% to the cost. Donations from other funding agencies and local institutions may cover the rest of the 30-35% of the cost. Total cost is estimated to be Tk. 35,948,430, equivalent to about (US$428,140).

# IV. Rural Health Programme of Grameen Kalyan

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Grameen Kalyan (a new member of Grameen family)

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   **Address:** Grameen Kalyan, Grameen Complex Mirpur-2, Dhaka 1216, Bangladesh
   **Telephone:** +880-2-900 2229/ 5257/ 5268/ 1213
   **Email:** g_kalyan@grameen.net
   **Fax:** +880-2-900 2229

3. **Contact person:** Mr. Shaikh Abdud Daiyan, Managing Director

4. **Type of organization responsible for the HMIS:**
   **X** non-profit health care provider: Grameen Kalyan is a not-for-profit company which manages the rural health programme (RHP) since August 1997.

5. **Year (and month) when the scheme was (formally) set up:** May 1993

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** May 1993

7. **Total number of male/female members of the scheme:** 27,339 families in 1999, rose from 13,000 families in 1993.

8. **Total number of members in the organization that has set up the scheme:** Entire Grameen members families

9. **Total number of current male/ female beneficiaries of the scheme:** 27,339 families in 1999, rose from 13,000 families in 1993. (Target population: population covered by the Grammen Health Centres, that is 3750-5250 families in each centre, totalling 41,250-57,750 families in all 11 centres)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** rural area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village

13. **Type of basic health care services covered by the scheme:**
    **X** preventive care and health promotion: free door to door service provided by health workers, with special emphasis on family planning, reproductive health, maternal and child health.
    **X** out-patient care: unlimited outpatient visits with a co-payment of 2 taka (about US$0.04) per visit
    **X** hospital treatment: 10% of hospitalisation cost (about Tk500-1,000)

- X medicines: 50% discount on 15 essential drugs; other drugs sold at below the retail prices.
- X others: 50-75%of the cost of basic pathological tests; 50% of the cost of specialist consultation; 50% on more sophisticated tests in referral hospitals (1997)

Note:, There are 11 health centres in 1999.

The above benefits coverage falls in different insurance package:

- 7 health centres provide an insurance package of ***Taka 50*** premium (US$1.04) per family per year, with a maximum of 10 family members. The insurance benefits include unlimited consultation with a doctor with Taka 2 (4 cents) of co-payment for each visit. In addition, it includes free annual health check up, 75% subsidy on basic pathological tests, medicine sold at prices lower than market prices as well as maternal and child health care in their own homes. This insurance package will end in the near future.
- 4 new centres plus a converted old centre now offer an annual premium of ***Taka 120*** (US$2.50) per family (maximum of 8 members) in return for physician consultations costing Taka 2 per visit, 50% subsidy on basic and extended pathological tests, free annual health check-up, 50% discount on the market price of 15 essential drugs and all other drugs are provided below the retail price. In addition to that, in case of referrals, it covers 50% of the costs of specialist and medical tests, and 10% of hospitalisation cost.
- 2 centres that offer the Taka 50 insurance package are now offering a new package for ***Taka 100*** (US$2.08). The insurance package provides all of the above mentioned benefits, except hospitalisation benefits.

**14. Method of financing the health insurance:**

- X members' contributions: 120 taka (about US$2.60) per family for Grameen members and 150 taka (US$3.30) for non-members (second package described above). If non Grameen members can organise in a group of five, they pay the same rate as Grameen members.

Note: The cost recovery rate for health centres providing Tk 120 and/or Tk 100 insurance package is on average 71.6% in 1998. For those that offer Tk 50 package, the average cost recovery rate dropped to 49%.

**15. Members' participation in the management of the scheme:**

- X administration by the organization responsible for the administration of the HMIS without members' participation other than choice of health services covered.

**16. External technical assistance**

- X receives punctual external technical assistance as required

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

The several reasons behind the set up of a rural health programme and its health insurance are as following:

- Sustaining the repayment capacity of members. A finding in a Grameen Bank report shows 44% of the defaulted loans were due to illness and poor health, preventing the borrowers from carrying out their economic activities and hence repaying the loans.
- Better health could accelerate economic growth and poverty alleviation
- To provide affordable health care to Grameen members and non-members alike within its operational area with a radius of 8 Km of a health centre.

Main objectives of RHP: (Quoting from Shaikh Abdud Daiyan's report)

- Provide effective and quality primary health care with special emphasis on family planning and maternal and child health at affordable prices and on a financially sustainable basis.
- Promote community-based health care programmes with effective involvement of people so as to encourage greater utilisation of health care services
- Improve the level of health awareness so as to promote effective change in the attitude, practice and behavioural pattern of the people
- Improve the health status of the community by reducing mortality and morbidity in specific areas so as to achieve the national health goals

Advantages and benefits:

- It requires a minimum of five families to subscribe to the GHP's insurance scheme, the same requirement as the Grameen Bank credit programme. This allows solidarity and social control being fostered among families.
- It uses sliding scale in its fee structure. Non-Grameen members (assumed to be better off than Grameen members), pay a little bit more than Grameen members in both premium and renewal rates.
- There is an existing large pool of potential clients from Grameen Bank membership.
- Increasing acceptance of local people

The study from Chao shows that in 1997, 85% of subscribers are Grameen Bank members, and this ratio has stayed rather constant over the few previous years.

The report of Shaikh Abdud Daiyan shows that 67% of patients treated at the health centres in the first 6 months of 1999 were insured Grameen Bank members. 31% of the patients are insured, but they are not Grameen Bank members, and the rest of the 2% is non-insured patients. So 98% of the patients who visited the health centres in that period are insured.

The number of patients being treated at all 11 health centres are increasing rapidly. In 1997, only 34,933 patients were treated. In 1998, it rose to 68,292. By the end of 1999, the figure stands at 107,173, of whom 62% were women. Hence, Grameen Kalyan's target of treating 100,000 patients in 1999 has been achieved.

**-Any bibliographical and written references:**

Chao, S. (1998) "Community Health Insurance in Bangladesh, A Viable Option?", draft paper.

Shaikh Abdud Daiyan (1999) "Grameen Kalyan, Rural Health Programme"

Kech, S. and Wagner, O. (1998) "Health Insurance linked to Community-Financing", STEP/ILO publication.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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# V. Proposed health insurance from Proshika health programme

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- *Dr. Qazi Faruque Ahmed, Executive Director and President*
- *Mahbubul Karim, Programme Director*
- *David William Biswas, Finance Director*
- *Md. Shah Newaz, Deputy Programme Director*
- *Md. Shahabuddin, Deputy Programme Director*
- *Qazi Khaze Alam, Deputy Programme Director*

Proshika was established in 1976 with the aim to improve the living condition of the population. Its operations cover 10,166 villages and 654 urban slums and has total membership of 1,296,922 in June 1997. 50% of the members are women and some 7,133,071 people benefited from its services.

It is one of the largest NGO in Bangladesh, involving in various activities like micro-credit assistance, training, formal and informal education, environmental protection and regeneration, housing, health infrastructure, research (its institute is called Institute for Development Policy Analysis and Advocacy (IDPAA) and providing support to business ventures of organised poor members.

In 1998, a plan was drawn to implement a health insurance pilot project in 6 Proshika centres (one centre covers a Thana). Premiums will be charged at a sliding scale according to the socio-economic status of the subscribers. It was planned to combine premium payments and co-payments to finance health services, with an objective to treat at least 5,000 patients a year. It would incorporate a referral system whereby patients who need higher level of care will be sent to Thana Health Complex.

The benefit package was not drawn up yet at the time Kech and Wagner's report was written.

The scheme aims at financially self-sufficiency.

**Reference:**

Kech, S. and Wagner, O. (1998) "Health Insurance linked to Community-Financing", STEP/ILO publication.

Note: the present exchange rate is US$1 = Tk49.37 (September 1999)

# India

I. Action for Community Organization, Rehabilitation and Development (ACCORD)

II. Association for Sarva Seva Farms (ASSEFA), Hyderabad

III. Co-operative Development Foundation (CDF)

IV. Integrated Social Security Scheme of SEWA

V. The Society for Promotion of Area Resource Centres (SPARC)

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## I. Action for Community Organization, Rehabilitation and Development (ACCORD)

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ACCORD has been working among the tribal communities at Gudalur, a small town, at the area of Nilgiris (bordering Kerala and Marnataka) in Tamil Nadu. The status of tribal people is being considered even lower than the lowest caste in the Indian society, and they are landless and working in exploitative conditions.

For over a decade, ACCORD built its comprehensive tribal development programme around campaigns for tribal people's land rights and to improve their working conditions. It organises tribal people into small groups at hamlet level (*sangams*) with a federative body called Adivasi Munnetra Sangam (AMS) on the top. Its development activities are related to employment generation, education, plantation, health, credit and so on, and are implemented through the *sangams*. The main emphasis is on participation and collective action. One of the major programmes of AMS is running a credit fund that allows members to contribute 1 Rupee per week, with a matching share from ACCORD, so that in case of emergency and serious indebtedness, members can borrow from the credit fund.

The health programme of ACCORD was conceived and carried out by community health specialists who trained health workers, especially women, to identify health-related problems, to monitor antenatal and immunisation programmes, and to spread health information. The programme also sets up a hospital in 1990 and initiated a "composite social insurance package" in partnership with an insurance company. Monthly premium is Rs.60 for a family of five, and it covers the risk of damage to their hut and belongings (up to Rs. 1,500), death and permanent disability of the head of family (Rs. 3,000), and all illnesses requiring hospitalisation (up to Rs.1,500).

This "composite social insurance package" received an encouraging response from the tribals but it encounters problems in collecting regular contributions and in insurance renewals. It is suggested by Eswara Prasad (1998) that linking up the insurance programme to the credit fund may ensure regular collection of premiums.

**Reference:**

Eswara Prasad, K. V. (1998) *ACCORD's health insurance for tribals (Gudalur, Tamil Nadu)*, in van Ginneken, W. (ed.), *Social security for all Indians,* New Delhi, Oxford University Press.

Jain, S. (1999) *Basic social security in India,* in van Ginneken, W. (ed.), Social security for the excluded majority: Case studies of developing countries, ILO, Geneva.

http://www.shared-interest.com/prod/pr24a.htm

http://www.shared-interest.com/prod/pr24b.htm

Other NGOs in India that work with tribal people can be found on http://www.indianngos.com/tribal.htm

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## II. Association for Sarva Seva Farms (ASSEFA), Hyderabad

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Association for Sarva Seva Farms (ASSEFA) is founded in 1969. It is a movement that operates in the Indian countryside, drawing its inspiration from Sarvodaya (the welfare of all). It is based in Tamil Nadu and Andhra Pradesh and is working in five other states. The organization encourages the formation of people's associations and is running various development programmes through them. In Hyderabad, ASSEFA has started a life insurance scheme that covers natural and accidental death and suicide of the insured member against an annual premium rate of Rs.10 for each family. The death benefits is a fixed rate of Rs. 3,000 per case.

A pilot project was carried out in Madurai area, and about 1,200 families were insured. The potential membership is large; it has 62,000 families who are members and ASSEFA covers 6,000 villages.

The organization is actively seeking ways to improve the scheme's financial viability, including the possibility of linking up with a life insurance company and/or removing the eligibility of claim under suicide.

ASSEFA is also running a comprehensive preventive and curative health services, including referral services, for about 4,000 families at different centres. The programme was initially funded by Plan International Programme, and managed by a committee with representatives from villages. By paying an annual premium of Rs.50 per family, a family can avail themselves of various services from the centres which are run by ASSEFA's own staff. Referral arrangement are made with government and non-government hospitals in Madurai. The hospitals provide free beds, meals and nursing care. For the rest of the cost, which is mainly medicine cost, two-third is paid by ASSEFA and one-third is paid by the beneficiary. Some income-generating activities have been started to support expenses in the health care scheme and operational deficit is declining.

**Reference:**

Jain, S. (1999) *Basic social security in India,* in van Ginneken, W. (ed.), Social security for the excluded majority: Case studies of developing countries, ILO, Geneva.

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# III. Cooperative Development Foundation (CDF)

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CDF was formed in 1982, by an association of primary agricultural cooperatives in Andhra Pradesh. It is formerly known as Samakhya, an institution which aims at "promoting an environment in which cooperatives flourish as decentralised, democratic, self help and mutual aid organizations, effectively harnessing and fostering local resources, in consonance with the principles of cooperation".

As part of its cooperative development work, CDF promotes and supports:

- women's thrift coops in the districts of Warangal and Karimnagar (both are in the state of Andhra Pradesh), which offer savings and credit services to their members
- cooperative thrift and credit system in the states of Andhra Pradesh, Karnataka, Goa and Tamil Nadu (it is a federation of 14 thrift and co-operative regional associations), which promotes urban and rural, workplace and neighbourhood, women's and men's thrift coops, bringing these and other existing thrift coops into regional associations and federates these for common financial services.
- paddy coops in the districts of Warangal and Karimnagar, which offer paddy storage, processing and marketing services to their members
- through its cooperative training and consultancy services, CDF also provides services on request to dairy coops, agricoops, their network members, and other cooperatives and cooperative development and financing agencies.

A Debt Relief Assurance Scheme, DRAS (previously known as death relief fund) was set up by CDF and is managed by Association of Thrift and Cooperatives (ATC)[2], to cover 22,850 women and 7,945 men members, as figure showed on 31 December 1999. The potential number of members of all thrift cooperatives who have not become members, but could be in the future stands at 28,308.

By paying an entrance fee of Rs 10 and a deposit of minimum Rs 50 along with an application form, a member or an employee of a thrift cooperative may join the scheme. A member can then make further deposits in multiples of Rs.50.

The scheme covers the risk of death[3] (natural or accidental, up to 60 years old). The debt relief benefits range from 5 to 20 times of the deposits, depending on the age of the member. The maximum debt relief benefit payment is Rs.10,000. The following chart illustrates this,

| Deposits kept during (years old) | Death benefits |
|---|---|
| 18-34 | 20 times of deposit |

[2] CDF promotes the primary level cooperatives, i.e. thrift cooperatives (TCs) and helps them to form associations of thrift cooperatives (ATCs). There is no organic link between CDF and TCs & ATCs; which have autonomous legal entities under India's cooperative law.

[3] Provided the death does not occur in a war, war like operations, communal disturbances and conflicts, riots, natural disasters like fire, earthquake, floods, cyclone, etc, and other disasters that may occur in work place or in community/ neighbourhood which may cause massacre (i.e, if more than ten deaths have taken on account of the same reason at the same place).

| | |
|---|---|
| 35-49 | 15 times of deposit |
| 50-54 | 10 times of deposit |
| 55-60 | 5 times of deposit |

A member who completes at least 5 years of membership in the scheme may be paid `retirement bonus' on his/her deposit at the end of his/her membership. This equally applies to those reaching 60 years old.

85% of the interest earned from funds collected and reserves maintained is deposited in a "DRAS Claim Fund" and rest of 15% in a "DARS Retirement Benefit Fund". All claims for debt relief benefits are settled from the DRAS Claim Fund and the retirement bonus is settled from DRAS Retirement Benefit Fund.

The other benefit under the scheme is security for the thrift co-operatives loans, which gives total debt relief for the surviving family and the guarantors.

Further details of DRAS:

- More than 50% of the beneficiaries of DRAS have income below the poverty line.
- In accordance with its advocacy, DRAS is managed democratically by its members, with general assembly.
- The scheme is reviewed at least once every two years by the General Body of the ATC.
- Lack of effective promotion is a reason given by CDF as a possible cause that members or employees of TC choose not to subscribe to DRAS
- CDF considers the DRAS is a simple, financially viable and sustainable and replicable scheme.

**Reference:**

Jain, S. (1999) *Basic social security in India,* in van Ginneken, W. (ed.), Social security for the excluded majority: Case studies of developing countries, ILO, Geneva.
A good description of CDF can be found at http://202.141.92.37/~cip/cipcdf.html

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# IV. Integrated Social Security Scheme of SEWA

*Contact: Mirai Chatterjee, General Secretary of SEWA, Sewa Reception Centre, Opp. Victoria Garden, Bhadra, Ahmedabad 380001, India.*
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SEWA is an organization that engages in many fields of development activities for women in the informal sector. In brief,

1) It is registered as a trade union to represent the interests of informal sector women workers and engage in collective bargain with employers.
2) It has various co-operatives under its umbrella, categorised mainly as health and child-care co-operatives, vendor co-operatives, artisan co-operatives, land and animal co-operatives, co-operatives for workers in the service sector
3) It owns a co-operative bank called SEWA Bank, providing general banking facilities and micro-credit to its bank members, who are SEWA members at the same time.
4) It offers insurance policies to its members, managed by SEWA Bank, which covers life, disability, asset, health and maternity. This micro-insurance system is called "Integrated Social Security Scheme", which was set up in 1992.
5) It offers legal aid to its members to fight for their rights as workers in the informal sector

SEWA's Integrated Social Security Scheme basically offers policyholders and beneficiaries insurance coverage in four areas:

- **Life insurance:** accidental death, insures both policy holder and spouse, up to Rs.10,000 (about US$231, US$1=Rs.43.12 in Nov. '99) and optional natural death covers only policy holder, up to Rs.3,000 p.a..
- **Disability insurance:** permanent disablement of a physical part of the body, insuring both policyholder and spouse, up to Rs.10,000.
- **Asset insurance:** loss of work equipment and/or housing unit due to riots, fire, flood and theft, insures policyholder only, up to Rs.2,000 per year for the former loss and Rs.3,000 per year for the later loss.
- **Health insurance:** covers various illnesses including gynaecological and occupational health related illnesses. Insurance coverage does not include chronic and/or pre-existing illnesses and it insures policyholder only, up to Rs.1,200 p.a..
- **Maternity insurance:** this is an extra and free coverage for policyholder who paid a lump-sum insurance premium for a life-time membership, which covers up to Rs.300 on deliveries and ante-natal care.

There are several options in premium payments:

- **Fixed deposit:** members who would like to enjoy life-time insurance membership (with all of the above coverage plus maternity coverage) can choose either Rs.500 or Rs.700 lump-sum payments. The latter amount provides all the mentioned coverage, includes the optional natural death coverage and insurance coverage for the spouse, while the former does not include this option and neither coverage for the spouse.
- **Annual payment:** members can choose either to pay Rs.60 or Rs.75 annually. Annual membership does not cover maternity insurance, but the rest of the benefits coverage is the same as fixed deposit membership, whereby the former does not get the optional coverage and the later does.
- **Monthly payment:** this is specifically designed for the very poor. A member can choose to pay Rs.5 monthly for the Rs.60 insurance plan, but there is no arrangement of a monthly payment for the Rs.75 insurance plan. Since it is assumed that the very poor only demand the basic package.

The annual membership of SEWA's Integrated Social Security Scheme has been increasing continously. For the fiscal year 1992/93, the scheme attracted around 5,000 members. Today (1998/99), its membership reaches 32,000. However, it only represents 15% of SEWA's trade union membership. It is not known exactly why 85% of SEWA's members do not choose to be insured.

The premium rates are generally considered affordable for SEWA members, since the real cost of the premium rates is actually three times what the members pay. One-third of the real premium cost comes from the government's subsidy, which is paid to Life Insurance Corporation, one of the two insurance companies that is in partnership with SEWA's Integrated Social Security Scheme, and act as the insurer for the life insurance. The other one-third is taken from the interests generated from the revolving fund offered by GTZ. So SEWA members only pay one-third of the real premium cost.

Some of the possible reasons as to why 180,000 SEWA members choose not to be insured are:

- Most of its members live in rural areas, hence the cost of getting into the city (Ahmedabad) to get reimbursement from the insurance is relatively high as compared to someone lives in the city
- Many of its members are illiterate. Even though there are health workers from co-operatives can help with form filling, it could still constitute a significant psychological

reluctance to get into something "complicated". Also, illiteracy is also a barrier to mobility.

- SEWA uses a network of co-operatives' workers to extend services and communicate with its members. It is not known, for example, how often on average a member gets in touch with a co-operative worker.
- Members may find the concept of savings for future health needs as more readily acceptable.

SEWA is implementing its decentralisation plan for its Integrated Social Security Scheme, with the aim to improve communication with its existing and potential members, to reduce the barrier imposed by geographical immobility, to increase management efficiency and to give local groups greater autonomy in managing their insurance funds. In the light of this, the potential of SEWA's Integrated Social Security Scheme to reach out its members and target group will be substantially enhanced.

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## V. The Society for Promotion of Area Resource Centres (SPARC)

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SPARC started its activities among slum dwellers and women pavement dwellers in Bombay and now has spread to 14 cities in India. It seeks to achieve through
(a) making local governments responsible and accountable to the people
(b) organising and empowering the people to demand the services rather than receive them as hand-outs.

SPARC has negotiated an insurance policy with a professional insurance company. An annual premium of Rs.30 will cover hospitalisation (normally at Rs.1,000), accidental death and disability for both the member and her spouse (Rs.25,000), partial disability (Rs.12,500), and loss of home, household goods and tools (Rs.3,000). SPARC supplements the premium with interests accrued from Rashtriya Mahila Kosh's (RMK) loans lent to its members. The potential number of insurance members is large, since SPARC has a membership of 9,000 families.

| Risks covered | Amount of benefits (Rs.) |
|---|---|
| Hospitalisation | 1,000 for major illness and an additional 4,000 for cancer |
| Accidental death (insured member)<br>Loss of two eyes or two limbs<br>Loss of one eye or one limb | 25,000<br>25,000<br>12,000 |
| Accidental death (husband)<br>Loss of two eyes or two limbs<br>Loss of one eye or one limb | 25,000<br>25,000<br>12,000 |
| Loss of home, household goods and tools for self-employment | 3,000 |

SPARC's women members are formed into groups known as "Mahila Milans", and collective leadership is promoted. It is running a successful crisis credit scheme that women are organised into saving groups. Small amounts (Rs.1 to 5) are saved daily and given to

collectors who in turn deposit the total amount at a central meeting place. Then needy members can borrow small amounts from this composite credit fund without complicated procedures that normally applies to traditional bank loans. Repayments from borrowers are also normally made promptly.

**Reference:**

Jain, S. (1999) *Basic social security in India,* in van Ginneken, W. (ed.), Social security for the excluded majority: Case studies of developing countries, ILO, Geneva.

# Nepal

I. Emergency funds of local solidarity/ Self-Help Groups

II. Maternity Benefit Scheme of Vijaya Youth Co-operative Credit Union, Newalparasi District.

III. Maternity Benefit Schemes of local mothers' groups.

IV. Medical Insurance Scheme of Lalitpur area of United Mission in Nepal

## I. Emergency funds of local solidarity/ Self-Help Groups

Many solidarity/ self-help groups in Nepal organised under various micro-finance programmes have some form of emergency fund. It is a regular levy upon members, which is usually linked to savings, and is available to cover emergency health costs or death benefits according to the rules of the group. Since most of these groups are small, normally with less than 20 members, the benefits provided are also quite modest, unless there is some sort of arrangement for pooling the resources through a central institution.

## II. Maternity Benefit Scheme of Vijaya Youth Club Credit Union, Newalparasi District.

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Vijaya Development Resource Centre (VDRC) in Newalparasi district is a local NGO established in 1979 as a Vijaya Youth Club. Now it has enhanced its capacity and extended its programme nationwide. Today, it has a total number of 2,035 members. 16 different kinds of activities have been performed by VDRC and one of its activity is Vijaya Youth Club Credit Union (VYCCU) Savings and Credit Programme that started in 1991. VYCCU is a community-based cooperative which is running 6 different types of savings and credit schemes: compulsory monthly savings, regular monthly savings, daily savings, piggy savings, optional savings and fixed deposit.

A "maternity allowance" was initiated in 1997 as a compulsory insurance for female members. Only female members of the savings and credit schemes are allowed to receive maternity allowance. It is not accessible to the wives of the male members. Fixed 300 rupees is given to a female member in each case and it is given twice only. Women can go to any hospital for giving birth and is obliged to bring necessary invoices to the cooperative. Then the cooperative directly pays to the hospital. The schemes has initiated by the VYCCU cooperative with the purpose of encouraging females to become member of the cooperative. They consider the scheme as a bonus for female savings and credit members.

This benefit is paid from the general income of the co-operative. Hence, there is no set premiums or fees. Strictly speaking, this maternity benefit scheme cannot be considered as

an insurance. However, the potential of extending the scheme to become a micro-insurance scheme exists.

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## III. Maternity Benefit Schemes of local mothers' groups.

A similar maternity benefit scheme is promoted by the Safe Motherhood Network, a coalition of local agencies working on maternal and child care issues. These agencies encourage local mother's groups to contribute a regular fee to a financial pool, which is managed by the Safe Motherhood Network. The fund is then used to pay for costs associated with child birth, delivery and sometimes other medical expenses too.

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Further information for all of the above schemes can be obtained from:
Anthony Scoggins Team Leader, Centre for Micro-Finance / National Savings and Credit Development Project,
Canadian Centre for International Studies and Co-operation (CECI)
P.O. Box 2959, Kathmandu, Nepal
Tel: 977-1-414-430 E-mail: anthonys@ceci.org.np
Fax: 977-1-413-256 Web Page: www.south-asia.com/cmf

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## IV. Medical Insurance Scheme of Lalitpur area of United Mission in Nepal

*Contact: Mr. N.S. Gurung, Project Director, Community Development Health Programme (CDHP), Patan Hospital, United Mission in Nepal (UMN), P.O. Box 126, Kathmandu, Nepal.*
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*Web site: http://www.umn.org.np/map.htm*
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Medical Insurance Scheme (MIS) was started in 1976 at the Lalitpur area by United Mission in Nepal. It was called Lalitpur Medical Insurance Scheme (LMIS). It is an annual renewable insurance plan for households in the area, allowing them to have better access to medicine. LMIS is designed only to cover the cost of medicines, and does not take into account of the cost of personnel and other supplies, transport, maintenance of the community health post etc, as these responsibilities belong to the government.

Later on, in 1983, the concept of Medical Insurance Scheme was applied at the community health post of Chaughare (at Lalitpur area). Then a year later, in Chapagaon(at Lalitpur area), and in 1986, MIS was extended to Bhattedanda (at Lalitpur area) and arriving in Gotikhel (at Lalitpur area) in 1988. Over the years, an additional registration fee has been charged in a couple of health posts with success. Until today, various health posts are still using MIS to help them be financially self-sustainable eventually.

**More details on the functioning of the medical insurance scheme**

A written agreement between the Community Development Health Programme (CDHP) and the local Health Committees allows the latter party to set the rules of the MIS. These rules include the annual premium rate for new household subscribers, the rate for those renewing during and after the 3 or 6 months registration period, and also the premium rate for new and old household members outside the target area of the specific health post. This is why the amount of premiums charged by each MIS participating health post is different.

When a person registers, he/she receives an insurance card with the registration number and all the names of the household members listed. A family file is then opened at the health post. Whenever a member of an insured household comes to the health post with his/her insurance card, it entitles him/her free medical service and appropriate medicines for an unlimited number of visits during the year.

If the beneficiary is referred to one of the hospitals operated by United Mission in Nepal (UMN), for example Patan Hospital, a referral hospital at Lalitpur area, the beneficiary goes with a referral paper and his/her insurance card. When he/she arrives at the hospital, he/she is taken to a special registration line and then to the appropriate doctor by the CDHP co-ordinator. At present, the first Rs.30 is deducted from the insurance benefits. If admission is required, the first Rs.200 is then deducted from it. In both events, the responsible doctor fills out his/her part of the referral paper that is returned to the CDHP's Community Medical Officer. Then the officer sends the record back to the health post so that appropriate follow up care can be provided, including special drugs may be prescribed. In the case of high-risk pregnant woman who is referred for admission, she will receive the treatment freely.

Medicines are supplied from UMN's Central Drug Store to supplement the medicines provided by the Ministry of Health via the District Public Health Office. Only medicines on the essential drug list are provided to the health posts. When medicines are sent to health posts each month to replenish the stock, the cost is debited to the MIS account.

The MIS account is kept at the CDHP's Business Office. It is credited with the annual drug subsidy from CDHP and District Public Health Office at the beginning of each financial year.

At the end of each month, the health post deposits the insurance premiums and registration fees into the health post committee's bank account and presents the cheque book to the CDHP's Business Office for verification. Most of the deposits are made during the registration period, which is usually the first three months of the financial year.

When the balance of the MIS account falls to zero, health post committee will have to transfer its money from the health post committee's savings account, which is earning about 8% of annual interest, to the MIS account.

Over the years, surpluses have been accumulated in the savings accounts of different health posts, and now most of the surplus have been deposited in Fixed Savings Accounts, earning 12-13% of interest.

The MIS population coverage (1998/99) at different health posts are as follow:

| Health Post | Target house-hold (HH) | Insured target HH | Insured non-target HH | Total insured HH | Target HH coverage (%) | Target HH coverage progress (%) | Overall coverage progress (%) |
|---|---|---|---|---|---|---|---|
| Ashrang | 964 | 464 | 139 | 603 | 48.13 | +9.13 | +17.31 |
| Bhattedanda | 1,383 | 610 | 52 | 662 | 44.10 | +5.35 | -13.06 |
| Chapagaon | 2,385 | 441 | 228 | 669 | 18.49 | -2.51 | -11.62 |
| Total | 4,732 | 1515 | 419 | 1,934 | 32.01 | -0.99 | -4.30 |

Figures is from CDHP's Lalitpur Area Annual Report (1998/99)

**Some of the mechanisms used to counter the problems**

1) Adverse selection

Many people wait until they are sick before purchasing the insurance plan. Insurance premium is set lower for those who register during the registration period than those after this period, and the premium rate for renewed household membership is lower than new household member. The mechanism has been shown to be effective and now, at least 75% of the premiums are paid during the registration period.

2) Over-utilisation of the health post services

At the beginning of the implementation of MIS, this was a concern. In fact, there is no sign of over-utilisation of medical services. It might be due to too much effort is needed to walk all the way to a health post in the mountains just for minor problems. In Chapagaon, a town with a concentrated population near the health post, an additional Rs.1 registration fee for each visit is enough to prevent over-utilisation

3) Management of the finance of schemes

- Initially, the communities were in charge of selling the insurance cards and handling the money. Soon it became clear that better control could be exerted by selling the insurance cards through the clerks (called mukhyas) at the health post and during membership recruiting trips to all the village development committees (VDCs).
- During the first few years, often the health committees did not pay CHDP for the drugs supplied. Starting from 1984, the supplies of drugs was withheld to the health posts until bills are cleared. Since then, the problems were reduced substantially.
- In 1992, it was discovered that one of the mukhyas was not depositing the premium money during the registration period. This person was dismissed rapidly and a tighter system of control on income and bank statements were implemented

4) The poor who cannot afford the insurance

It was stated in the report by Richard Harding (1993) that it continues to be a problem, even with free services. Poor people, those who live far away from the health post, and those who are incapacitated only use the health post facilities very occasionally. Recently, several health committees have started a charity fund that wealthier people and visitors can contribute. No one is denied emergency service.

**Some of the strengths of MIS**

1) There has been excellent support and acceptance of MIS, with the exception of Bungmati and Badegaon, where the health posts closed due to community politics or lack of interest. Larger, more educated families, Brahmans and Chetri, and those live close to the health post tend to become members of MIS.

2) The cost of drugs and most premium rates have risen at the same rate over the years. With increased enrolments, premiums collected managed to cover at least 50% of the drug costs for nearly all the schemes, without including the subsidies from CDHP and

District Public Health Office. For Chapagaon in 1991-1992, it even managed to cover 73% of the drug costs.

# Philippines

I. Angono Credit and Development Co-operative (ACDECO)

II. Bukidnon Health Insurance Programme (BHIP)

III. Community Health Care Project of Guihulngan District Hospital, Negros Oriental, Region VII: Peso For Health

IV. Co-operative Health Emergency Assistance Programme (CHEAP)

V. Federation of BHWs of Surigao del Norte's Health Insurance

VI. Guimaras Health Insurance Programme (GHIP)

VII. HEWSPECS Pilot Community Based Health Maintenance Organization (CBHMO)

VIII. Linabo Parish's Medical Health Care Insurance Programme for Students

IX. Lunas Damayan – Bagong Silang Primary and Multi-Purpose Cooperative

X. Lunas Damayan – Pagkakaisa ng Kababaihan

XI. Lunas Damayan – Pandayan Multi-Purpose Cooperative

XII. Maibo Bulig-Bulong Programme (MBBP) in South Cotabato

XIII. Medical Mission Group Hospitals & Health Services Cooperative (MMGHHS)

XIV. Medicare Programme II Project, Sampaloc, Quezon

XV. Medicare Programme II Project, Unisan, Quezon

XVI. Novaliches Development Cooperative, Inc. (NOVADECI)

XVII. ORT Health Plus Scheme in La Union

XVIII. San Isidro Medicare II Project

XIX. Silago Multi-Purpose Co-operative's Coop Medical Aid Plan

XX. Tarlac Health Maintenance Programme

XXI. Tribal Women's Health Project

# I. Angono Credit and Development Co-operative (ACDECO)

ACDECO started as a community co-operative in 1966 with only 27 members. By 1999, its membership reached 3,500. They are mainly small entrepreneurs, employees and farmers. ACDECO operates various financially viable social programmes and has become a multi-purpose cooperative. Its programmes include loan protection plan, the Damayan, enterprise development training, grocery and pharmacy services, medical and optometry services, sale of consumer products, printing services, mortuary services and memorial lots. In 1991 alone, ACDECO extended capital loan to small business in the amount of P14.48 million, some P3.3 million for repair of houses and over a million pesos for medical and educational purposes.

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Angono Credit and Development Co-operative (ACDECO)

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   **Address (state country):** Col. JP Guido Street, San Roque, Angono, Rizal, Philippines.
   **Telephone:** +63-2-651 0601 / 0603
   **Email:**
   **Fax:**

3. **Contact person:** Mr. Nemesio Miranda, Senior ACDECO Manager

4. **Type of organization responsible for the HMIS:**
   **X** co-operative-type organization

5. **Year (and month) when the scheme was (formally) set up:** late 1980s

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** late 1980s

7. **Total number of male/female members of the scheme:** estimated a total of 2,500 members

8. **Total number of members in the organization that has set up the scheme:** 5

9. **Total number of current male/ female beneficiaries of the scheme:** 2,500 members

10. **Proportion of beneficiaries a) excluded from other social security systems or b) with income below the poverty line:**
    **X** between 25 and 50%

11. **Place of residence for the majority of members:**
    **X** rural area
    **X** urban surrounding

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village

13. **Type of basic health care services covered by the scheme:**

- X out-patient care
- X medicines
- X other: discount on dental services

**14. Method of financing the health insurance:**
- X members' contributions

**15. Members' participation in the management of the scheme:**
- X democratic administration of the scheme by members (general assembly)

**16. Technical assistance**
- X does not receive external technical assistance

**17. Other (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

This scheme is driven by a strong social security orientation of the cooperative. Membership has been made virtually mandatory by the cooperative, which is often difficult among Filipino cooperatives.

The cooperative operates a number of small enterprises such as a grocery, printing press, small pharmacy, and cemetery development and management. The co-op members collectively own these small enterprises but most of them are not employed in these enterprises.

Many cooperative members are small businessmen and depend on the cooperative for operating capital.

The scheme seems viable. The project managers have a strong foundation in financial management and risk management because of their credit operations. Its weaknesses lie in the lack of primary health care services.

**-Any bibliographical and written references:**

Philippine Country Paper: Institutionalizing Indigenous Social Protection Schemes for Homeworkers and other Workers in the Informal Sector, ILO-DANIDA Sub-regional Workshop on Indigenous Social Protection Schemes, January 24-28, 1995, Chiangmai, Thailand

**-Names of persons and/or organizations that can provide additional information about the scheme:**

Ms.Lou Hernandez, National Confederation of Cooperatives, 227 J. P. Rizal ST. , Project 4, 1109 Quezon City, Philippines.

Tel. (632)9137011-14

Fax:(632)9137016

E-mail: natcco@wtouch.com.ph

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***Loan Protection Programme***

This programme assures the viability of the co-operative despite of loan default due to member's death. It only requires a monthly payment of P1 for every P1,000 loan. The loan protection programme does not cover delinquent loans. The premium for the loan was determined without professional actuarial study, but has served well through the years.

The difference between this programme and CLIMBS's loan protection plan is that the premium of the later is based on the age of the borrower while ACDECO's programme is not. Hence older borrower needs not pay higher premium.

***Damayan***

It is a mutual benefit plan that, at the beginning, provides P10,000 to the deceased member's family and P6,000 for the death of every spouse or child (regardless of number) of the member, provided the child is a minor at the time of death. When the programme was started, the monthly contribution of P30 was based on the co-operative's 1,200 membership.

The programme also pays P10,000 to members who have suffered disability by the age of 65. In addition, the concerned member receives monthly pension of P500 up to 15 months. If disability occurs at age 70 and he/she has not withdrawn his fixed contributions, he/she is entitled to a lifetime monthly pension of P500. Only members of the co-operatives not more than 55 years old could join this programme.

Today, the highest benefit under the programme has been increased to P25,000, based on a higher monthly premium of P60. However, the members are not required to find new cash contribution from their pockets as the new premium is drawn from the interest earnings of the members' patronage fund. The contribution of the members for the patronage fund range from P100 to P720 per year and they get the corresponding benefits. The system was developed based on the annual ratio of dying members to paying members in previous years and the expected benefits. Its benefits are higher than other para-insurance schemes that are provided by sister co-operatives like CLIMBS.

***Medical and Optometry Services***

ACDECO also provides free medical and optometry services to its members through its clinic. However, its services need further improvement to compete with other service providers.

**Reference:**

*Philippine Country Paper: Institutionalising Indigenous Social Protection Schemes for Homeworkers and other Workers in the Informal Sector*, ILO-DANIDA Sub-regional Workshop on Indigenous Social Protection Schemes, January 24-28, 1995, Chiangmai, Thailand.

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# II. Bukidnon Health Insurance Programme (BHIP)

**Brief description:**

The programme began in 1994 with the participation of the Philippine Medical Care Commission, a multi-sectoral advisory council and the Local Government Unit. This province-based health insurance programme has approximately 24,000 subscribers since its inception up to February, 1998. Contributions come solely from members, however the programme receives budgetary support from the provincial government. To date, this support amounts to P45.8 million (1994-1998). A set of outpatient and inpatient medical and dental services is provided by a pool of accredited private and public health professionals. Providers are compensated on a capitation basis for outpatient cases and on a

fee-for-service basis for inpatient cases. The administration of the programme is handled by a team of employees paid by the provincial government.

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Bukidnon Medicare Programme II Advisory Council, Provincial government of Bukidnon

2. **Address of the HMIS Head Office (or contact address of the responsible organization ):**
   ***Address:*** BHIP Office, Provincial Capitol, Malaybalay, Bukidnon**,** Philippines
   ***Telephone:*** +63-88-841-2297
   ***Fax:*** +63-88-841-3178

4. **Contact person:**
   Dr. Melquisedes Po, Chairman of BHIP Advisory Council, President of PHA (private provider)
   Ms. Marilyn Goles, Deputy Project Director, BHIP
   Fr. William Yap, Vice Chairman of BHIP (representative of the beneficiaries)
   Mr. Francis Intong, Presiding officer and provincial administrator

4. **Type of organization responsible for the HMIS:**
   **X** others: Local Government Unit. The provincial government of Bukidnon is the initiator of this scheme.

5. **Year (and month) when the scheme was (formally) set up:** February 1994

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** February 1994
7. **Total number of male/female members of the scheme:** 15,136 as of December 31, 1995, increased to 24,000 in February 1998 (The critical mass is estimated to be 30,000 members)

   Note: Each barangay health worker (BHW) has 20 families in his/her catchment area, 5% commission is paid to BHW from premium collection. That means BHW can provide insurance coverage for his/ her family by maintaining the membership status of their catchment areas. As of July 1996, the commission was increased to 10%.

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 75,983 as of December 31, 1995 (Target population: all residents of Bukidnon Province, including Medicare covered residents.)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** rural area
    **X** urban area
    **X** urban surroundings

12. **Geographical area covered by the health micro-insurance scheme:**

**X** province/region: 22 municipalities of the province

**13. Type of basic health care services covered by the scheme:**

**X** outpatient care: consultation with family doctor is P30 per visit

**X** hospital treatment: P5,000 covers doctors services and hospitalisation expenses, which include accommodation, medicines, laboratory and other diagnostic services; professional fees of the family doctors and during hospital confinement.

**X** midwife services/ reproductive health care: may be claimed for the first normal or first complicated delivery after being a member for 10 months.

**X** medicines: P1,500 per family per year (average per outpatient medicine is P150, equals to 2 days doses)

**X** others: dental treatment is P500 per family per year (consultation, extraction, prophylaxy, permanent filling); laboratory and other diagnostic services are P500 per year.

**14. Method of financing the health insurance:**

**X** members' contributions: The annual membership contribution is P720 per member per year. However a 25% discount is given to those members who give a one-time full payment. A 10% discount is given to those who pay semi-annually. Quarterly payments are P180 per member per quarter.

**X** state contribution: subsidy

Note: An indigent programme is supported by the provincial government, means test is included in the enrolment process. First year is subsidised by the province, second year usually by the municipality. Criteria for selecting indigent members:

- Per capita power consumption for applicant
- Per capita water consumption
- Distance to nearest health service provider
- Health awareness, practices of applicant
- Bonus point for farming families with vegetable garden

As of April 1995, 25% of the total subscribers received the following subsidies of their premium:

29% received 50% subsidy
35% received 37.5% subsidy
26% received 25% subsidy; and
10% received 12.5% subsidy

Financing method (as of April 1995):

***Revenue****:*

Premium contribution: 33.71%

Provincial subsidy: 66.29% (3.15% for premium subsidy; 63.14% on operation; 25.68% on administration)

**Costs:**

Expenses were P2.37 for peso of premium collection and P1.70 benefit payment for every peso of premium collection.

**15. Members' participation in the management of the scheme:**

**X** administration by the organization responsible for the administration of the HMIS without members' participation other than choice of health services covered.

**16. External technical assistance**

Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

Problems encountered include,

- Security of safekeeping and remittance of premium collection to the regular barangay treasurer.
- Active membership declined during 1994 from 100 to 58 at the end of the year
- Late payments
- Limited use of the management information system (MIS). Its use is confined to printing out the lists of members and dependants for health care providers and to issuing passbooks

Recommendations suggested by the Social Health Insurance-Networking and Empowerment (SHINE) are:

- Strengthening internal organization
- Adjust the distribution of health care providers on the municipal level.
- Quantify the target set for indigent coverage.
- Implements utilisation control measures against moral hazard, a problem of excessive availment of health care services
- Move away from high subsidisation and towards internal revenue finance
- Subsidy should be shared between lower local government unit (LGU) levels.

**-Any bibliographical and written references:**

SHINE Health Insurance Infos. All figures are valid as of December 31, 1995.

*Overview of Social Protection Schemes in the Philippines* of Working Conditions Improvement, Enterprise Development and Social Protection Schemes in support for the Informal sector, SEAPAT, ILO.

HAMIS 1998.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

Ms. Marilyn Goles or Mr. Antonio Sumbalan, Provincial Planning and Development Office, Malaybalay, Bukidnon

Anne Nicolay, Project Manager of Social Health Insurance-Networking and Empowerment (SHINE),
1611 Citystate Center, 709 Shaw Blvd., Pasig City, Philippines
Tel: +63-2-636 1383 / 1387. Fax: +63-2-637 5721.
E-mail: shine@philonline.com

Bernadette Carmela B. Magtaas, Assistant Project Manager of SHINE
Tel: +63-2-434 9078 / 9079 Fax: +63-2-434 9077

# III. Community Health Care Project of Guihulngan District Hospital, Negros Oriental, Region VII: Peso For Health

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Guihulngan District Hospital

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
***Address:*** Gov. William Villegas Memorial Hospital (formerly Guihulngan District Hospital), Guihulngan, Negros Oriental

3. **Contact person:**
Dr. Fidencio G. Aurelia, Chief of Hospital, Gov. William Villegas Memorial Hospital

   Note: This programme has other project partners including Guivalaca Integrated Health Workers' Service, the municipal government units and other sectors

4. **Type of organization responsible for the HMIS:**
   **X** others: Guihulngan District Hospital is a government hospital. However, this hospital based insurance project is owned and managed by the community

5. **Year (and month) when the scheme was (formally) set up:** December, 1994

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** January, 1995

7. **Total number of male/ female members of the scheme:** 1,005 households and 5,100 members

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 5,100 (Target population: residents of the four municipalities, a total of 201,223 in 1994)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** rural area
    **X** urban area
    **X** urban surroundings

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** province/region: municipalities Guihulngan, Vallehermoso, La Libertad and the City of Canlaon

13. **Type of basic health care services covered by the scheme:**
    **X** preventive care and health promotion: growth monitoring, immunisation and nutrition control for the young; blood pressure and thermometer reading, health education for adults; environmental sanitation and other preventive/promotion services.

- X hospital treatment: 30% discount on laboratory examination, X-ray, EKG, Oxygen, dental or other medical procedures and facilities during hospitalisation
- X medicines: up to P200 per member

Note: Waiting period before benefits can be availed of is 6 months.

**14. Method of financing the health insurance:**

- X members' contributions: membership fee is P10 per household and monthly premium is one peso per member

**15. Members' participation in the management of the scheme:**

Information not available

**16. External technical assistance**

Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

**-Any bibliographical and written references:**

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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## IV. Co-operative Health Emergency Assistance Programme (CHEAP)

***Contact:*** *Mount Carmel Kilusang Bayan for Credit, Inc., c/o Bienvenido Ravida, Cor. Granja and Guinto Streets, Lucena City, Region IV, Philippine*

**Background**

It was started in 1987 with an objective to provide loans with low interest rate for livelihood projects and medical emergencies to members of the co-operative, small vendors and indigent. The main beneficiaries include the poor of Lucena City.

**Medical care programme**

By paying an annual contribution of P55, members of the co-operative are entitled to P400 emergency financial assistance once a year, if they are hospitalised for at least 48 hours. The co-operative's health fund is generated through members' annual contributions, which are deducted from members' interests earned on share capital and patronage refund. There are plans to extend the benefits coverage to include medical services like dental and optical treatments under this scheme.

The present services that are offered under CHEAP:

- Death benefits under Damayan programme
- Savings programme
- Loan for livelihood projects at 9-15% interest
- Minimum monetary benefits from P1,000 to P2,000
- Small economic assistance programme (SEAP)

- Educational plan
- Pension plan
- Offering credit cards
- Housing programme
- Medical check up per year for members
- SSS made accessible

Some of these activities are in operation since 1972.

The number of beneficiaries increased from 202 in 1990 to 3,566 in 1994, and their fixed deposit increased from P100 to P500.

Sources of fund include annual membership fees, cash prize from HAMIS award, medicine sales and solicitation.

Considering the size of the co-operative (with 2,611 members), it is a promising base for risk-sharing among members.

**Reference:**
Schwefel D. and Palazo E.D. (1995) *HAMIS Health and Management Information System*, Department of Health of Philippine and Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)

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## V. Federation of Barangay Health Workers (BHWs) of Surigao del Norte's Health Insurance

***Contact:*** *Angelita J. Bullo, BHW Coordinator, Surigao del Norte*
***Possible contact address:*** *Integrated Provincial Health Office/ Barangay Health Workers Botica Coop., Provincial Health Office, Surigao City, Surigao del Norte.*

The Federation of BHW of Surigao del Norte was formed in July 1991. One of the many services it provides is health insurance. Each month, the member pays P10 for health insurance, which was deducted from honorarium. This allows each member (the BHW) to enjoy an annual benefits of P200 per day for 3 days.

**Reference:**
Schwefel D. and Palazo E.D. (1995) *HAMIS Health and Management Information System*, Department of Health of Philippine and Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)

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## VI. Guimaras Health Insurance Programme (GHIP)

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Provincial Government of Guimaras, Region VI, Philippines (Dr. Joaquin Carlos Rahman Nava, Provincial Governor), Provincial Capitol, Jordan, Guimaras

2. **Address of the HMIS Head Office (or contact address of the responsible organization): Address:**

**Telephone:** +632-915-030328
**Email:**
**Fax:** +632-915-030328

3. **Contact person:**
   Dr. Elvin H. Tiangha, Programme II Medicare Claim Adjudicator
   Ms. Luz P. Catalan, HEPO II, GHIP

4. **Type of organization responsible for the HMIS:**
   **X** others: local government unit. This scheme is implemented as a locally initiated health insurance scheme. The provincial government funds and implements this scheme in the entire province.

5. **Year (and month) when the scheme was (formally) set up:** 1993

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 1993

7. **Total number of male/female members of the scheme:** members: 9,094 and dependants: 29,274, as of March 31, 1996 (24% of the total households)
   Note: Barabgay Health Workers (BHWs) are given incentives to recruit members for BHW is paid P5 for each member recruited to GHIP. For every 50 recruited subscribers, one household member gets free GHIP membership/ coverage.

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 57, 836 (45% of the target population), increased from 38,368 in March 1996 (Target population: 130,000 population from the 5 municipalities. Children up to 21 years old are regarded as dependant.

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    **X** more than 50%

11. **Place of residence for the majority of members:**
    **X** rural area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** department: 5 municipalities: Neuva Valencia, Buenavista, Jordan, San Lorenzo, Sebunag

13. **Type of basic health care services covered by the scheme:**
    **X** outpatient care: free on professional consultation fee.
    **X** hospital treatment: 100% accommodation charges for 20 days (shared between policyholder and beneficiaries); 100% operating room fee.
    **X** medicines: P600 on medicine for ordinary illness; P900 for intensive condition; P1,500 for very serious condition.
    **X** others: free routine laboratory services; 10% discount on special laboratory services; 15% discount on X-ray screening; 50% discount on ECG

Note: Since there is no private hospital in Guimaras, the Provincial Hospital and two Medicare Hospitals (10 bed primary care hospitals) are the designated providers of the scheme. The waiting period before a member can avail of benefits is 15 days.

**14. Method of financing the health insurance:**

**X** members' contributions: P60 per year

**X** state contribution: Province pays P25 and Municipalities pay P15. Salaries of the administrative staff comes from the province.

Note: total cost of premium is thus P100. Qualified indigents can receive coverage for free; the province pays P85 and the municipality pays P15. Mutual initiatives on barangay level allow higher income households subsidise other not qualified indigents.

**15. Members' participation in the management of the scheme:**

Information not available

**16. External technical assistance**

**X** receives punctual external technical assistance as required: at the end of May, Guimaras Health Insurance Programme installed a computerised Claims Processing System developed by the SHINE Project.

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

Guimaras is an island province which is one of the twenty poorest provinces in the Philippines. 75% of the population lived below poverty line. The health care services in the area is expensive with inadequate health facilites and a lack of private hospitals.

It was started as a province-wide health insurance programme in 1993 with the participation of the Philippine Medical Care Commission (PMCC), Local Government Unit, Provincial Health Office, Provincial Health Board, and Provincial Hospital.

A large proportion of the population, particularly the poorer occupational groups and the unemployed, could not afford the premiums under programme I (National Health Insurance for the employees in the formal sector). Guimaras Health Insurance Programme is one of Philippine Medical Care Commission's Programme II pilot projects. It is supposed to expand Medicare coverage to include the low-income self-employed and non-members of Programme I. Programme I members may also participate provided they claim Programme II benefits only after they have availed Programme I's benefits.

Problems that have been encountered include

- Backlog in encoding transactions
- Error in the billing system
- Claims against MCHF (Medicare Community Health Fund) are limited to ward accommodation and drugs
- The process of qualifying as an indigent is expensive and requires transparency
- Lack of permanent monitoring system of the premium collection process
- Lack of a monitoring system of the total programme cost

It is fair to say that the GHIP is a cost recovery programme for drugs.

**-Any bibliographical and written references:**

SHINE Health Insurance Infos. Information on GHIP was obtained at the end of 1997.

*Overview of Social Protection Schemes in the Philippines* of Working Conditions Improvement, Enterprise Development and Social Protection Schemes in support for the Informal sector, SEAPAT, ILO.

**-Names of persons and/or organizations that can provide additional information about the scheme:**
Further details can be obtained by contacting
Anne Nicolay, Project Manager of Social Health Insurance-Networking and Empowerment (SHINE),
1611 Citystate Center, 709 Shaw Blvd., Pasig City, Philippines
Tel: +63-2-636 1383 / 1387. Fax: +63-2-637 5721.
E-mail: shine@philonline.com

Bernadette Carmela B. Magtaas, Assistant Project Manager of SHINE
Tel: +63-2-434 9078 / 9079 Fax: +63-2-434 9077

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# VII. HEWSPECS Pilot Community Based Health Maintenance Organization (CBHMO)

***Contact:*** *Hewspecs, Inc (Health, Education & Welfare Specialist), c/o Elynn N. Gorra, 11 Lipton St., Phase 2 G, Filinvest Homes, Batasan Hills, Q.C., Philippines.*
***Telephone:*** *+63-2-430 4134/ 931 4501 or +63-918-880 183*

This programme was initiated by USAID, the DOH and the Philippine Council for Health Research and Development (PCHRD) to test the feasibility and viability of alternative means of generating resources for community health. Two types of communities were selected after preliminary social investigation. The low and middle income families from San Antonio, Binan, Laguna, and the corporate community represented by the University of Philippines which is not enjoying health care benefits beyond those required by law.

The primary objectives of this pilot CBHMO are:
- To make health care available and affordable to low and middle income households;
- To generate new resources for health care at the community level;
- To help achieve financial self-reliance for health care at the community level.

The research objectives of this pilot CBHMO are,
- To test the feasibility of the Health Maintenance Organization (HMO) as a means of financing community health care;
- To determine the factors and conditions that could contribute to or hinder the development of a community-based HMO;
- To assess the potential of developing the HMO as a financing scheme in other communities.

The CBHMO scheme uses its own infrastructure to deliver and finance the health services. Its basic principles are based on risk-sharing, group health practice, preventive maintenance and systematic referral. These principles allow the cost of health care to be minimised.

CBHMO scheme targets low and middle income families earning between P1,000 and P3,000 monthly. Members pay a fixed price for a defined package of health services. The low and middle income families are offered the Community Plan and the University of Philippines is offered the Corporate Plan. Updated prices for these plans are not known.

Services provided include medical consultation, medical and laboratory tests and annual examinations.

Benefits that are offered to members include,

**Outpatient care:**

- unlimited consultations
- unlimited authorised laboratory and other diagnostic exams
- any number of treatments for illnesses and injuries not requiring confinement
- free annual routine physical exams
- hospital co-ordination in accredited facilities

**Inpatient care:**

- professional fees of physician
- subsidised hospital expenses according to a schedule of fees

The number of members for the Community Plan increased from 700 in 1991 to 900 in 1994, and for the Corporate Plan, it increased from 250 to 362 respectively.

**Reference:**

Schwefel D. and Palazo E.D. (1995) *HAMIS Health and Management Information System*, Department of Health of Philippine and Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)

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## VIII. Linabo Parish's Medical Health Care Insurance Programme for Students

***Contact:*** *Father William Yap, Jr., former Parish Priest, Linabo Parish, Malaybalay, Bukidnon, c/o Bukidnon Health Insurance Project, Malaybalay, Bukidnon, Philippines*
***Telephone:*** *+63-88-841-2297*
***Fax:*** *+63-88-841-3178*

One of the 9 programmes that were organised in 1994 is the Medical Health Care Insurance Programme for Students. This was initiated at St. Michael High School in Bukidnon Province. 410 students contributed ten pesos (P10) per month for their medical care at a private hospital at the province. This entitles students to outpatient care benefits amounting to P1,500 per year; in-patient benefits up to P2,500 per year; and a lump-sum benefit for surgery of P3,000 per year.

**Reference:**

Schwefel D. and Palazo E.D. (1995) *HAMIS Health and Management Information System*, Department of Health of Philippine and Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)

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***Contact:*** *Dr. dennis badangan, Guimba Health Maintenance Project*
***Fax:*** *+63-44-6112011 (field office)*
***Fax:*** *+63-2-436 2992 (manila office)*

The following three schemes that are called Lunas Damayan are part of the Guimba Health Maintenance Project (GHMP), a health insurance scheme initiated in August 1997 by the People Managed Health Services and Multi-purpose Co-operative (PMHSMPC) of Nueva Ecija. As of December 1997, its coverage was 0.07% of the population. A fixed contribution is paid for by each member in exchange for a set of inpatient and outpatient services with ceilings and discounts. The GHMP runs a primary care clinic to cater for the outpatient needs of its clients while 2 hospitals and 5 doctors are paid on a fee for service basis for the inpatient care. An HMO specialist and an administrative team take care of performing the insurance functions of the project. This project is heavily funded by a German agency and other local funding sources.

**Reference:**
*Overview of Social Protection Schemes in the Philippines* of Working Conditions Improvement, Enterprise Development and Social Protection Schemes in support for the Informal sector, SEAPAT, ILO.

HAMIS 1998

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# IX. Lunas Damayan – Bagong Silang Primary and Multi-Purpose Cooperative

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Bagong Silang Primary and Multi-Purpose Cooperative

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   **Address (state country):** Bagong Silang Primary and Multi-Purpose Cooperative Cabaruan, Guimba, Nueva Ecija, Philippines
   **Telephone:**
   **Email:**
   **Fax:**

3. **Contact person:** Mr.Candido Emana, Sr., General Manager.

4. **Type of organization responsible for the HMIS:**
   **X** co-operative-type organization

5. **Year (and month) when the scheme was (formally) set up:** 4 August 1998

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 4 August 1998

7. **Total number of male/female members of the scheme:** 158 members in 1999 (The cooperative has a total of 466 members, with 459 of them are male members)

8. **Total number of members in the organization that has set up the scheme:** 10

9. **Total number of current male/ female beneficiaries of the scheme:** 158 members in 1999

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    **X** more than 50%

11. **Place of residence for the majority of members:**
    **X** rural area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village

13. **Type of basic health care services covered by the scheme:**
    **X** preventive care and health promotion
    **X** out-patient care
    **X** hospital treatment

14. **Method of financing the health insurance:**
    **X** members' contributions

15. **Members' participation in the management of the scheme:**
    **X** democratic administration of the scheme by members (general assembly)

16. **Technical assistance**
    **X** receives regularly external technical assistance

**People Managed Health Services and Multi-Purpose Cooperative (PMHSMPC)**
Mr. Arnel Peter Bartolome, Project Coordinator
Guimba Clinic, Ramos Street, Guimba, Nueva Ecija, Philippines
Tel./fax.: +63-44-6112011

Ma. Theresa Vibar-Mercurio
Institute of Public Health Management
136-A Maginhawa St., UP Village, Quezon City, Philippines
Tel.: +63-2-4359254
E-mail: iphm@bigfoot.com

17. **Other (if applicable):**
    **-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
    This is a small-scale, simple HMIS, managed competently by a functional cooperative, which was set up relatively recently in 15 September 1992. The HMIS receives adequate technical support and therefore reduces risk of flawed technical design. It's weaknesses lie in the small and homogenous risk pool and the highly seasonal harvest (members of the cooperative are mainly garmers and vendors of agricultural produce). Typhoons and other factors that affect the harvest also affect the financial reserves of this HMIS.

    Other services of the cooperative includes providing loans and provision of farm inputs to its members, as well as health services.

**-Any bibliographical and written references:**

**-Names of persons and/or organizations that can provide additional information about the scheme:**
Ma. Theresa Vibar-Mercurio, Institute of Public Health Management

136-A Maginhawa St., UP Village, Quezon City, Philippines.

Tel. +63-2-4359254, E-mail: iphm@bigfoot.com

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# X. Lunas Damayan – Pagkakaisa ng Kababaihan

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Pagkakaisa ng Kababaihan

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   **Address (state country):** Guimba Clinic, Ramos Street, Guimba, Nueva Ecija, Philippines
   **Telephone: +**63-44-6112011
   **Email:**
   **Fax:**

3. **Contact person:** Mrs. Rosalinda Dizon, President

4. **Type of organization responsible for the HMIS:**
   **X** other: a women's association which is under the patronage of the mayor's wife

5. **Year (and month) when the scheme was (formally) set up:** January 1999

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** January 1999

7. **Total number of male/female members of the scheme:** more than 5,000 members, all female

8. **Total number of members in the organization that has set up the scheme:** 5

9. **Total number of current male/ female beneficiaries of the scheme:** 276

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    **X** more than 50%

11. **Place of residence for the majority of members:**
    **X** rural area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village

13. **Type of basic health care services covered by the scheme:**
    **X** preventive care and health promotion

X out-patient care
X hospital treatment

**14. Method of financing the health insurance:**
X members' contributions

**15. Members' participation in the management of the scheme:**
X members' involvement in the organization responsible for the administration of the health micro-insurance scheme

**16. Technical assistance**
X receives regularly external technical assistance

**People Managed Health Services and Multi-Purpose Cooperative (PMHSMPC)**
Mr. Arnel Peter Bartolome, Project Coordinator
Guimba Clinic, Ramos Street, Guimba, Nueva Ecija, Philippines
Tel./fax.: +63-44-6112011

Ma. Theresa Vibar-Mercurio
Institute of Public Health Management
136-A Maginhawa St., UP Village, Quezon City, Philippines
Tel.: +63-2-4359254
E-mail: iphm@bigfoot.com

**17. Other (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
The Pagkakaisa ng Kababaihan is a social network of women headed by the mayor's wife, with a membership of more than 5,000 members. Its purpose is to assist members in their time of need, by engaging in various services like education, livelihood projects and health services. Its members are mainly housewives, small entrepreneurs engaged in agricultural business and retailing. Lunas Damayan was set up at the same time when Pagkakaisa ng Kababaihan was formally registered.

It is the patronage of the mayor's wife keeps the network together. The HMIS is therefore very vulnerable to political risk due to local partisan politics. Political instabilities are likely to hamper the growth of this scheme.

**-Any bibliographical and written references:**

**-Names of persons and/or organizations that can provide additional information about the scheme:**
Ma. Theresa Vibar-Mercurio, Institute of Public Health Management

136-A Maginhawa St., UP Village, Quezon City, Philippines.

Tel. +63-2-4359254, E-mail: iphm@bigfoot.com

# XI. Lunas Damayan – Pandayan Multi-Purpose Cooperative

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Pandayan Multi-Purpose Cooperative

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   **Address (state country):** Purok 3, Maturanok, Guimba, Nueva Ecija, Philippines
   **Telephone: +**63-44-6113287
   **Email:**
   **Fax:**

3. **Contact person:** Mr. Romeo Sursula, General Manager of Pandayan Multi Purpose Cooperative

4. **Type of organization responsible for the HMIS:**
   **X** co-operative-type organization

5. **Year (and month) when the scheme was (formally) set up:** 8 April 1999

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 8 April 1999

7. **Total number of male/female members of the scheme:** 19 males and 32 females

8. **Total number of members in the organization that has set up the scheme:** 3

9. **Total number of current male/ female beneficiaries of the scheme:** 19 males and 32 females

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    **X** more than 50%

11. **Place of residence for the majority of members:**
    **X** rural area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village

13. **Type of basic health care services covered by the scheme:**
    **X** preventive care and health promotion
    **X** out-patient care
    **X** hospital treatment

14. **Method of financing the health insurance:**
    **X** members' contributions

15. **Members' participation in the management of the scheme:**
    **X** democratic administration of the scheme by members (general assembly)

**16. Technical assistance**

**X** receives regularly external technical assistance

**People Managed Health Services and Multi-Purpose Cooperative (PMHSMPC)**

Mr. Arnel Peter Bartolome, Project Coordinator

Guimba Clinic, Ramos Street, Guimba, Nueva Ecija, Philippines

Tel./fax.: +63-44-6112011

Ma. Theresa Vibar-Mercurio

Institute of Public Health Management

136-A Maginhawa St., UP Village, Quezon City, Philippines

Tel.: +63-2-4359254

E-mail: iphm@bigfoot.com

**17. Other (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

This micro-insurance naturally only has a small membership, hence a small risk pool, as it was only set up in April 1999. With a local economy strongly relies on agriculture, fluctuating seasonal income and recent poor harvests in the local community does not help other members of the local community to join the cooperative and pay premiums for this micro-insurance scheme.

Social capital is an asset in this group. At the moment, this micro-insurance scheme may be considered as relatively unstable as compared to those with bigger risk pools. Nonetheless, it is a valuable service for its members.

**-Any bibliographical and written references:**

**-Names of persons and/or organizations that can provide additional information about the scheme:**

Ma. Theresa Vibar-Mercurio, Institute of Public Health Management

136-A Maginhawa St., UP Village, Quezon City, Philippines.

Tel. +63-2-4359254, E-mail: iphm@bigfoot.com

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# XII. Maibo Bulig-Bulong Programme (MBBP) in South Cotabato

This programme was initiated through the leadership of Barangay Captain Darroca and was organised as part of a project of the Institute of Primary Health Care-Davao Medical School Foundation (IPHC-DMSF). Starting with only 34 families in 1996, more than 100 families in 1997 received benefits of the programme which include medical and dental coverage in accredited hospitals and clinics for members and their dependants as well as laboratory tests and consultation.

**Reference:**

Development Research News of Philippine Institute for Development Studies, Vol. XV No.6, Nov.-Dec. 1997

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# XIII. Medical Mission Group Hospitals & Health Services Cooperative (MMGHHS)

***Contact:*** *Dr. Jose M. Tionco*
***Address:*** *MMG Philippine Federation, c/o Medical Mission Group of Davao City, Leon Garcia Street, Agdao, Davao City, Philippines*
***Tel****: +63-82-221 9118*

Area of operation: Address

Lanao del Norte: Quezon Avenue, Iligan City, Lanao del Norte.

Davao: MMG Clinic & Hospital, Bo. Obrero, Davao City.

Eastern Visayas: c/oPHCCI Building, Real St., Tacloban City, Leyte

Quezon: No.1, Ravanzo St., Quezon Avenue, Lucena City, Quezon.

Sorsogon: Mapsaysay St., Sorsogon

Bulacan: Bocaue

This is a health insurance scheme managed by co-operatives in different regions. The health insurance scheme is called Cooperative Health Fund, it provides health care to cooperative members and/or employees. Members may choose from three types of coverage with varying amounts of annual contribution.

The Fund is jointly owned by doctors, health workers, patients and cooperative members and managed by the cooperatives. It intends to make health care as accessible to its members and the local community as possible. Surplus fund will earn interests at the cooperative bank or will be invested elsewhere for higher profit.

This concept was pioneered in 1991 at Davao City by Medical Mission Group Davao (MMG Davao). Since then, various primary health care cooperatives were set up in other regions. Today, it covers 30 areas and 42 hospitals in Philippines.

The following describes the various Plans available.

***Plan A*** requires P1,200 a year (P112/month) premium and entitles the holder to a total health care benefits package on out-patient treatments and admittance to the ward section of the Medical Mission Group Hospital.

***Plan B*** is for dependants of Plan A holders and costs P1 per day or P365 a year. The benefits are limited to free outpatient consultations and free hospitalisation not exceeding P5,000 per confinement.

***Plan C*** costs P1,800 a year and offers total health care benefits similar to Plan A but holders may be confined in private rooms of the Medical Mission Group Hospital.

MMGHHS is considered as a large organization. It's adopting various measures to ensure the fund can sustain the health services it provides to its members.

MMGHHS management complained that the members abused the utilisation of services and sought consultation to the doctor even for minor illnesses.

**Reference:**

Development Research News of Philippine Institute for Development Studies, Vol. XV No.6, Nov.-Dec. 1997
http://www.gsilink.com/user/mmgcebu

# XIV. Medicare Programme II Project, Sampaloc, Quezon

This project was initiated in 1994 with the involvement of the Philippine Medical Care Commission (PMCC) and the Municipal Government of Sampaloc, Quezon. The scheme was implemented in a in a similar manner as the Guimaras Health Insurance Scheme. However, the project may now be on a standstill because the Mayor who spearheaded this project failed to win a post in the last election.

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** *Municipal Government of Sampaloc, Quezon*

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   **Address:** *Municipal Hall, Sampaloc, Quezon Province, Philippines.*

3. **Contact person:**
   Agnes V.S.T. Devanadera (former Mayor of Sampaloc)
   Dr. Jaime Galvez Z. Tan (former Undersecretary of Department of Health)

4. **Type of organization responsible for the HMIS:**
   **X** others: Local Government Unit. The municipal government of Sampaloc municipality was responsible for the implementation and funding of this scheme.

5. **Year (and month) when the scheme was (formally) set up:** 1994

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 1994

7. **Total number of male/ female members of the scheme:** approximately 800 self-employed families

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** (Target population: all residents of Sampaloc, with the self-employed as the main target group. Total self-employed families in Sampaloc is around 2,500.)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** rural area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village

13. **Type of basic health care services covered by the scheme:**
    **X** outpatient care: free consultation, discounted diagnostic services
    **X** hospital treatment: free hospital accommodation, doctor's visit and operating room, limited benefits on medicines/ laboratory test, X-ray, surgeon fee and anaesthesia

**X** medicines

Note: the two main medical service providers are Sampaloc Medicare Hospital and Quezon Memorial Hospital. Inpatient care in another hospital will be reimbursed provided necessary supporting documents are submitted.

**14. Method of financing the health insurance:**

**X** members' contributions: Plan A: P180 per year; Plan B P120 per year.

Note: most members choose Plan A

**15. Members' participation in the management of the scheme:**

Information not available

**16. External technical assistance**

Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

Strengths:

- Community involvement on Purok level
- Innovative and efficient insurance premium collection method
- Social mobilisation at community level is easier and controllable

**-Any bibliographical and written references:**

SHINE Health Insurance Info.

*Overview of Social Protection Schemes in the Philippines* of Working Conditions Improvement, Enterprise Development and Social Protection Schemes in support for the Informal sector, SEAPAT, ILO.

HAMIS 1998

**-Names of persons and/or organizations that can provide additional information about the scheme:**

Anne Nicolay, Project Manager of Social Health Insurance-Networking and Empowerment (SHINE),
1611 Citystate Center, 709 Shaw Blvd., Pasig City, Philippines
Tel: +63-2-636 1383 / 1387. Fax: +63-2-637 5721.
E-mail: shine@philonline.com

Bernadette Carmela B. Magtaas, Assistant Project Manager of SHINE
Tel: +63-2-434 9078 / 9079 Fax: +63-2-434 9077

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## XV. Medicare Programme II Project, Unisan, Quezon

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** *Municipal Government of Unisan, Quezon Province*

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**
***Address:*** *Municipal Hall, Unisan, Quezon*

3. **Contact person:**

4. **Type of organization responsible for the HMIS:**
   **X** others: Local Government Unit. The municipal government of Unisan, Quezon is responsible for the implementation and funding support of this scheme.

5. **Year (and month) when the scheme was (formally) set up:** since early 80's

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:**

7. **Total number of male/ female members of the scheme:** 500

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 500 plus dependants (spouse and children up to 18 years old) (Target population: all residents of Unisan)

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    **X** rural area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** commune/village

13. **Type of basic health care services covered by the scheme:**
    **X** hospital treatment: free hospital accommodation and doctor's visit and limited benefits on medicines, laboratory test etc.

14. **Method of financing the health insurance:**
    **X** members' contributions: three options: P60, P120 or P180 per year

15. **Members' participation in the management of the scheme:**
    **X** administration by the organization responsible for the administration of the HMIS without members' participation other than choice of health services covered.

16. **External technical assistance**
    Information not available

17. **Others (if applicable):**
    **-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
    Weakness:
    - Fluctuating membership. Membership is heavily dependant on the political support and funding receives from the mayor
    - Lack of self-sustaining programme and continuos information campaign

- Delayed reimbursement to the health care providers, especially after the resignation of the former programme co-ordinator in 1995. Backlog of medicine payments for the hospital amounted to P50,000.
- Lack of transparency in fund management, operational procedures, enrolment process.
- Lack of community participation. The programme works like a new charity and without encouraging reliability.

**-Any bibliographical and written references:**
SHINE Health Insurance Info.

**-Names of persons and/or organizations that can provide additional information about the scheme:**
Anne Nicolay, Project Manager of Social Health Insurance-Networking and Empowerment (SHINE),
1611 Citystate Center, 709 Shaw Blvd., Pasig City, Philippines
Tel: +63-2-636 1383 / 1387. Fax: +63-2-637 5721.
E-mail: shine@philonline.com

Bernadette Carmela B. Magtaas, Assistant Project Manager of SHINE
Tel: +63-2-434 9078 / 9079 Fax: +63-2-434 9077

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## XVI. Novaliches Development Cooperative, Inc. (NOVADECI)

***Contact person:***

*Christeta Viesca, General Manager of NOVADECI*

*Martha Bautista and Aurora Bautista, Assistant General Manager of NOVADECI*

NOVADECI was founded in 1976 by a group of pork vendors when the slaughter house in Susano Market at Novaliches was closed down, to overcome their financial difficulties. Today, NOVADECI has grown to become one of the top millionaire cooperatives in the Philippines.

Providing credits continue to be its primary economic activity, but its services now include insurance, medical and health care services, training and education.

Market vendors comprised 60% of the total membership. The rest are micro-entrepreneurs (15%), professionals(10%), self-employed service sector workers(10%) and students(5%). So 85% of NOVADECI members are employed informally.

The majority (77% from a sample survey) of the members are women, working in informal sectors like retailing and services. They earn an average of P8,000 per month, and maintains an average individual fixed deposit of P20,000.

NOVADECI offers two types of social security programmes: the Damayan Programme and the NOVADECI Health Care Plan.

Its **Damayan Programme** offers:

- **Death benefits**
- **Old-age retirement pension (called the *Gabay sa Katandaan*)**
- **Total/ partial disability pension**
- **Loan Guarantee Programme (LGP)**

The Damayan death benefits was the first social security service offered by NOVADECI. It provided members with simple mortuary and funeral cash assistance. Over the years, the package has increased to include cash benefits for the beneficiaries at between P30,000 and P200,000. Beneficiaries also can receive an amount equivalent to the total amount of savings the deceased had with the co-operative.

The disability and *Gabay sa Katandaan* (retirement) Pension Programmes were introduced later. They were intended to assist members in the event of loss of income resulting from unemployment due to injury or old age. Partial disability allows allows members to receive a maximum amount of P1,500 monthly pension for two years, plus an initial lump sum cash benefits equal to the fixed deposit (but not more than P15,000). For total disability, the members will receive the same amount of benefits, but the pension will extend to five years. For old age pensioners (those over 65 years old), they are entitled to a maximum lump sum cash benefits of P15,000, plus a monthly pension of P1,500.

The Damayan Programme is financed from two funds: the **Pondo Para sa Damayan (PPD)** and the **Damayan fund**. The former is an individual savings account worth P400 that is maintained by a Damayan member. The latter is a reserve fund financed through the PPD.

The PPD finances the Death benefits scheme. When a Damayan member dies, the other members each contribute a fixed amount (P50 for death of a co-member, P15 for death of member's parent/ spouse, and P10 for death of member's child), which is deducted from their individual PPD. The pooled contributions pay for the cost of the claim, and whatever excess money goes to the Damayan fund. Members can top up their PPD through automatic deduction from their regular savings, interest earned on capital, patronage refunds, or subsequent loans.

The Damayan fund is a reserve fund which finances the other Damayan Programme's services, i.e. old-age pension, total/ partial disability pension and Loan Guarantee Programme. In 1991, the fund amounted to over P500,000. By 1998, it worthed more than P7 million. This phenomenon growth is believed to be due to aggressive recruitment of new members and competent handling of the fund. Each year, NOVADECI recruits around 700 and 800 new members who contribute to the Damayan fund. The Damayan fund is then allowed to revolve within the cooperative to help finance the cooperative's lending activities. Because of this, the Damayan fund earns 8% interest per annum.

The Loan Guarantee Programme (LGP) is intended to reduce the risk of non-payment of loans due to the death of a member-borrower. To secure a loan, the premium is P2.10 for every P1,000 three-month loan and an additional P0.50 for every one month extension in the loan period. The guarantee covers up to P300,000 of the unpaid loan. LGP essentially secures both the cooperative and the family of the deceased member from non-payment of loan.

**NOVADECI Health Care Plan (NHCP)**

NOVADECI Health Care Plan started in 1993, and is very similar to commercial health insurance, only being more affordable. To qualify, a member must have a fixed deposit of at least P2,000 and pay an annual fee of P600. In return, the member and his immediate family are provided with free medical consultation, free pregnancy delivery, free annual medical check-up and discounted laboratory examinations, dental and optical services. Hospitalization benefits for members are up to P10,000, while for immediate family members, hospitalization benefits are up to P5,000.

The NHCP does not enjoy the same success as the Damayan Program. Since its introduction, membership have reached a little over a thousand, a mere 20 percent of NOVADECI's total membership. Because of the low participation rate, financing of the program has become problematic. Possible factors are:

1) the existence of a coop medical service program which already caters to most of members' basic medical and health care needs.Because medical services are already provided free or at discounted rates, there is little incentive to participate in the new NHCP.

2) low confidence in the capability of NOVADECI's medical staff. Doctors employed under NHCP are qualified licensed general practitioners, but members prefer specialists.

3) lack of an effective marketing strategy to launch the health care program. The majority of the members has little understanding of the mechanism of NHCP and the benefits it offers.

4) limited health coverage of the program. For example, heart problems, a common illness among members, are not covered by NHCP.

To entice more members into NHCP, NOVADECI has begun constructing a new clinic which will house new laboratories and medical equipment. The cooperative will likewise hire specialists and introduce more types of medical services (e.g. x-ray) to accommodate the growing complex medical needs of members.

According to the survey conducted on 100 NOVADECI members, only 37 out of the 783 (or 4.7%) loans availed of the members were in the form of emergency loans. This may suggest that the Damayan Program has effectively responded to the social security needs of the members, negating in effect the need for members to avail of emergency loans

Some observations revealed that a substantial number of new recruits joined the cooperative mainly for the purpose of availing of Damayan benefits. Citing records of the cooperative, membership has increased substantially from 1,983 in 1991 to more than 5,900 in 1997 when the Damayan Program started to peak.

The above description is a summary of the NOVADECI case from the paper written by Reginald Indon.

**Reference:** "Social Security in the Informal Sector: two case studies" by Reginald M. Indon of Institute on Church and Social Issues.

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## XVII. ORT Health Plus Scheme (OHPS) in La Union

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** ORT Community Multi-Purpose Cooperative

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** World ORT Union Philippines, Guerrero Road, San Fernando, La Union
   ***Tel:*** +63-72-888 5080
   ***Tel and fax:*** +63-72-242 5158

3. **Contact person:**
   ***Name:*** Avi Kupferman, Regional Director of Asia and person in charge of OHPS
   Mrs. Cynthia Lao, Project Manager of ORT Community Multi-Purpose Cooperative
   ***Address:*** 5 San Ignacio St., Urdaneta Village, Makati City 1225, Philippine
   ***Tel and fax:*** +63-2-815 4093
   ***Additional Tel:*** +63-2-810 6447
   ***Mobile phone:*** +63-(0)912 319 1803
   ***Email:*** ortphil@ibm.net; akupfe1@ibm.net

4. **Type of organization responsible for the HMIS:**
   **X** co-operative-type organization

5. **Year (and month) when the scheme was (formally) set up:** July 1994

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** July 1994

7. **Total number of male/ female members of the scheme:** 160 families (end of 1994), 282 families (end of 1995) and 653 families (by Sept. 1999).
   Note: 1,875 families, with 8,400 individuals enrolled over the 5 years. This includes multiple enrolment of families who have dropped out and rejoined the scheme.

8. **Total number of members in the organization that has set up the scheme:** 556 (End of 1995)

9. **Total number of current male/ female beneficiaries of the scheme:** around 3,500 individuals (by Sept. 1999) (Target population: all members of the ORT Multi-Purpose Co-operative, family members of the children attending ORT Day Care Centre and the general population of the barangays in which the centres are located).

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    **X** between 25 and 50%

11. **Place of residence for the majority of members:**
    **X** rural area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** province/region

13. **Type of basic health care services covered by the scheme:**
    **X** preventive care and health promotion: free immunisation is provided by ITRMC in collaboration with Rural Health Care Units
    **X** outpatient care: free consultations are provided by doctors and nurses at the ORT day-care centers, the ORT Central Unit, and at the OHPS Clinic at Ilocos Training and Regional Medical Centre (ITRMC) on a regular weekday basis. On weekends and holidays, emergency consultations are provided at ITRMC- out-patient department and/or emergency room. Specialist consultation, laboratory tests (except Ultrasound) and X-rays are provided to all members at ITRMC.
    **X** hospital treatment: In-patient services are provided to members for up to 45 days free of charge by ITRMC only upon referral from the OHPS, and upon presentation of a valid OHPS membership card. Services include room and board, doctors' services like medical examinations and surgery, drugs, X-ray and laboratory tests. OHPS will not cover services provided by ITRMC without referral or approval except emergencies. Also it will not cover for special accommodation services (private room, telephone and TV in-patient room) and specialist fee.

- **X** midwife services/ reproductive health care: free pre-natal and baby care is provided by ITRMC in collaboration with Rural Health Care Units
- **X** medicines: free for essential drugs prescribed by OHPS doctor or nurse at the ORT day-care centres, ITRMC and ORT Central Unit. Drugs prescribe for use following discharge from the hospital will be dispensed by the OHPS at the Central Unit and day-care centres. Over-the counter or non-prescription drugs are sold to members at reasonable prices (20% markup) and to non-members at 50% markup.

Note: Medical services, including nurse and doctor consultations and drugs may be provided to non-insured residents in the barangays in the ORT day-care centres and Central Unit at defined charges, which will be higher than the monthly contribution rate. These services will not include hospital care.

:Services that are not covered include dental care and optometrist care, cosmetic surgery, dialysis, orthopeadic pins/plates and specialist care that is not provided by ITRMC, such as organ transplant and open-heart surgery. Medication for chronic illnesses (diabetes mellitus, tuberculosis, hypertension etc.) are not included but will be sold (if available) at affordable prices.

: Primary health care benefits will be given after payment of one month's contribution and in-patient benefits will be provided after 2 months' contribution. Benefits will not be given if the monthly contributions have not been made for two consecutive months and more than one interruption of one month over a twelve months period.

: Maternity benefits will only be provided after 6 months contribution. Patients should be seen by the OHPS Physician at least 6 times prior to expected date of delivery. Services will be provided to new-born children when their names are registered on the family membership card and there is no qualifying period.

Source: OHPS, September 1999

**14. Method of financing the health insurance:**

**X** members' contributions

Single (18 years old and above): P70.00/month

Standard Family (up to 6 members): P120.00/month

Large family (more than 6 family members): P150.00/month

Source: OHPS, September 1999

Note: A person can join every first week of the month. The first payment will have to be submitted within one week of joining. Payments can be arranged as monthly (pay on the first week of every month), quarterly (first week of every March, June, September December) and bi-annually (first week of January and July of every year).

New members will have to pay initially 3 months contribution and then can choose between paying monthly, quarterly or bi-annually according to their preference.

**15. Members' participation in the management of the scheme:**

**X** democratic administration of the scheme by members (general assembly)

**16. External technical assistance**

**X** receives regular external technical assistance

The Australian International Development gave a one-off donation of 100,000 pesos (about US$4,000). It was used for the purchase of a computer and the adaptation of the health rooms. There is no assistance/subsidy/technical help coming from them since then. Other sources of technical assistance have been provided since then include,

Dr. Aviva Ron, WHO Consultant

Dr. Ma. Eufemia Yap, Executive Director, HealthDev Foundation.

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

The ORT Health Plus Scheme (OHP) was established in mid-1994 as a non-profit community based health insurance system for the residents of areas served by the ORT's Mother and Child Community Integrated Project in La Union Province, Philippines. The administrative structure to manage OHPS is the ORT Multipurpose Cooperative, created through the ORT Project and governed by a Cooperative Board. The central office of ORT is in San Fernando, La Union.

The following shows the structure of the health services provided.

| Name of provider | Services | Number |
|---|---|---|
| Ilocos Training and Regional Medical Hospital | Tertiary hospital for in-patient care and laboratory and auxiliary services | 1 |
| OHPS doctors | Primary health care and regular medical consultations | 5 |
| OHPS nurses | Primary health care, referral services | 8 |

Difficulties experienced include (source: OHPS situation report, September 1999)

1. Drop out rate is relatively high due the following reasons:

1.1 irregular or seasonal source of income

1.2 lack of full understanding of social health concept, policies, and procedures

1.3 too high expectations of members from providers (e.g. full coverage of all medicines prescribed, everyday presence of doctors in satellite clinics)

2. Drug supply: difficulties in making available sufficient stock of medicines at all times, in all locations, which include the Central Unit and 13 satellite clinics.

3. Wide geographical area covered. Distances of clinics are relatively far apart.

4. Delayed remittances of premiums and payments of medicines from members.

5. Understanding the concept of social health insurance was not easily achieved even among the staff involved in the program that caused several areas of misunderstanding and misinterpretation.

6. First hospital provider (private) was not able to grasp the concept of social health insurance that prompted OHPS to choose another hospital provider.

7. Lack of support from other sectors like the local government units, government line agencies, and even medical practitioners.

8. Conflicting of interest with some OHPS doctors acting also as private practitioners.

9. Clients often misunderstood policies and procedures.

**Overall changes made on the scheme:**

1. After one year in operation, the scheme transferred to another hospital provider.

2. The qualifying period for maternity care was increased to 12 months, following several cases of abuse, through payment of contributions for three months prior to delivery and then dropping out after delivery.

3. The premiums were increased by around 20 percent, after 5 years. A major reason was the increase in the cost of drugs. The decision was taken through the ORT Multipurpose Cooperative Board.

4. The information system has been expanded to enable a computerised membership database, and the monitoring of utilisation of all referred patients. A discharge summary of all members admitted to hospital (ITRMC) is provided by the hospital. The information system also handles drug procurement and distribution to the satellite clinics.

5. At the primary health care level, all consultations are entered, with name, sex and age of patients, reason for visit and the referred services, as well as drug prescription.

**-Any bibliographical and written references:**

*Overview of Social Protection Schemes in the Philippines* of Working Conditions Improvement, Enterprise Development and Social Protection Schemes in support for the informal sector

Bennett, S., Creese A. and Monasch, R. (1998*) Health Insurance Schemes for People Outside Formal Sector Employment*, WHO, Current Concern ARA Paper number 16.

*A Community health insurance scheme in the Philippines: extension of a community based integrated project,* Macroeconomics, Health and Development Series, WHO.

*ORT Philippines 1995*, ORT Philippines.

Ron, A. and Kupferman, A. (1996) *A Community health insurance scheme in the Philippines: extension of a community based integrated project*, Philippines Technical Paper, Macroeconomic Health and Development Series No.19, WHO.

Kupferman, A. (Sept.1999) "ORT Health Plus Scheme: OHPS data for OHPS situation report, September 1999".

**-Names of persons and/or organizations that can provide additional information about the scheme:**

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## XVIII. San Isidro Medicare II Project

This scheme was initiated under the leadership of Mayor Justina Yu of San Isidro in Region XI. It aimed to supplement the Medicare I programme of the national government. Under Medicare I, only workers receiving regular income and salary may subscribe. San Isidro Medicare II project was then formulated to serve the members of Mayor Yu's municipality who are not salaried, such as farmers, drivers, vendors and others.

A member only has to pay an annual fee of P240 to receive medical benefits such as free room and stay in accredited hospitals, free X-rays, coverage of medicine expenses from P500 to P700 for ordinary cases and from P600 to P1,000 for intensive care cases, subsidised fees for laboratory procedures, and free medical and dental consultation for outpatients, among others.

**Reference:** Development Research News of Philippine Institute for Development Studies, Vol. XV No.6, Nov.-Dec. 1997

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## XIX. Silago Multi-Purpose Co-operative's Coop Medical Aid Plan

***Contact:*** *Ms. Socorro Mate, Manager of Silago Multi-Purpose Co-operative, Silago, Southern Leyte*

The co-operative established a Coop Medical Aid Plan for its members. Any coop member with a fixed deposit or a contribution of at least P200 is qualified to participate in the plan.

A person interested to participate in the plan is required to pay P25 as his reserved contribution annually. Medical coverage will start three months from the date of enrolment and after paying the full amount. The total medical aid is limited only to P500 for a given calendar year. The member can extend his benefit to any of his beneficiaries (parents, spouse, children below 18 years old).

There are 250 coop members who joined the Coop Medical Aid Plan. They are from a diverse background, ranges from farmers, housewives, labourers, to small entrepreneurs and professionals.

A good lesson learned from the scheme is that co-operatives are good channels for health financing and insurance schemes.

**Reference:**
Schwefel D. and Palazo E.D. (1995) *HAMIS Health and Management Information System*, Department of Health of Philippine and Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)

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## XX. Tarlac Health Maintenance Programme

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Tarlac Health Maintenance Co-operative (THMP)

2. **Address of the HMIS Head Office (or contact address of the responsible organization):** Tarlac Provincial Hospital, Tarlac, Tarlac.

3. **Contact person:**
   Augusto M. Canlas, Programme Manager
   Roman L. Belmonte (Chairman of the national surgeon association), Board member of Tarlac
   Consorcia L. Quizon (Vice Chairman)(former PHO), Board member of Tarlac
   Ricardo P. Ramos (Director), Board member of Tarlac
   Antonia G. Mosuela (Director), Board member of Tarlac

4. **Type of organization responsible for the HMIS:**
   **X** co-operative-type organization

5. **Year (and month) when the scheme was (formally) set up:** March 1995

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:**

7. **Total number of male/ female members of the scheme:** 1,444 in July 1996

8. **Total number of members in the organization that has set up the scheme:**

9. **Total number of current male/ female beneficiaries of the scheme:** 1,087 in July 1996
   Note: if a policyholder is married, those dependants who can be beneficiaries are the legal spouse, unmarried/unemployed children, step-children below 21 years old, and disabled children. If a policyholder is unmarried, his/her parents who are 60 years old and above can be beneficiaries.

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    Information not available

11. **Place of residence for the majority of members:**
    - **X** rural area
    - **X** urban area
    - **X** urban surroundings

12. **Geographical area covered by the health micro-insurance scheme:**
    - **X** province/region

13. **Type of basic health care services covered by the scheme:**
    - **X** outpatient care: P300 for regular consultation; P900 for diagnostic services
    - **X** hospital treatment: Inpatient care includes hospital accommodation, medicines, diagnostic services, doctor's visit, OR fee, surgeon fee and anaesthesia.
    - **X** medicines: The Department of Health provides the essential drug list in the Philippines Drug Formulary. Only drugs and medicines used that are part of this list are reimbursable.

    Note: If premium is paid in full, the waiting period is one month. If premium is paid in instalment, the waiting period is three months.

14. **Method of financing the health insurance:**
    - **X** members' contributions: P1,200 per year for lump-sum payment, otherwise it is P660 for every 6 months, or one may choose quarterly payment of P348 or monthly payment of P120.
    - **X** state contribution: premiums of indigents are subsidised by the state
    - **X** others: co-payment of 19% is paid by user for the health care services

15. **Members' participation in the management of the scheme:**
    Information not available

16. **External technical assistance**
    - **X** receives punctual external technical assistance as required: Technical Assistance was provided by USAID Health Finance Development Project (HFDP) in the development of the Operations Manual and its Management and Information System. The government helps to channel support from various foreign technical assistance groups.

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

Problems encountered include:

- Insufficient number of subscribers
- Technical problems with the THMP software (it's more of a databank than an infobank)
- Advice in limiting benefits utilisation is not adopted
- Membership renewal rate is unsatisfactory
- Diagnoses are not encoded according to World Health Organization's ICD system.
- PMCC/PHIC supports only the initial training of health counsellors, the initial supply and initial training of the adjudicator
- Management and decision-making process lack transparency
- There is no referral mechanism.

**-Any bibliographical and written references:**

SHINE Health Insurance Info.

Bennett, S., Creese A. and Monasch, R. (1998*) Health Insurance Schemes for People Outside Formal Sector Employment*, WHO, Current Concern ARA Paper number 16.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

Anne Nicolay, Project Manager of Social Health Insurance-Networking and Empowerment (SHINE),
1611 Citystate Center, 709 Shaw Blvd., Pasig City, Philippines
Tel: +63-2-636 1383 / 1387. Fax: +63-2-637 5721.
E-mail: shine@philonline.com

Bernadette Carmela B. Magtaas, Assistant Project Manager of SHINE
Tel: +63-2-434 9078 / 9079 Fax: +63-2-434 9077

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# XXI. Tribal Women's Health Project

***Contact:*** *c/o Mrs. M. G. Uyasan, Project Coordinator, Tribal Women's Health Project, Santa Cruz Mission, Lake Sebu, South Cotabato*

Health insurance component:
Each family contributes P10 per month as clinic membership for medicines, health services, consultation and hospitalisation.

**Reference:**

Schwefel D. and Palazo E.D. (1995) *HAMIS Health and Management Information System*, Department of Health of Philippine and Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)

# Thailand

I. Klong Pia Credit Union in Songkla

II. Sri Haruethai Klung Credit Union

## I. Klong Pia Credit Union in Songkla

***Contact:*** *ILO/STEP Asia focal point*
***Tel:*** *+41-22-799-6544*
***Email:*** *step@ilo.org*

This is a growing credit union with attractive lending and saving schemes, as well as various welfare benefits funds for its members.

Monthly interest of loans are set at Baht 1 and dividend is set at 4.5%, on par with the bank's interest rate. Today, the union's membership has grown to over 4,000 and has a revolving fund worth more than Baht 50 million.

It finances its various welfare benefits funds from the profits made by paying different interest rates to members who save with the union for 12 months or more and others who save for less than 12 months.

- **Funeral benefit fund**

Baht 500 per funeral for the family of the member

- **Natural disaster and accident benefit fund**

Baht 2,500 per disaster per member. The fund is used to cancel the debts with the union when members die.

- **Medical benefit fund**

70% of the medical expenses (community hospital, doctor and medicine costs) of members are covered. The management intends to cover 100% from year 2001.

- **Education benefit fund**

15 scholarships of Baht 500 each per year are available to Wat Chong Khao school

- **Occupational training benefit fund**

Each year Baht 60,000 is allocated to cover training of members who intend to set up a business with money they saved with the credit union.

**Reference:**

Ponne, I. (1999) *Indigenous Social Protection Schemes, The case of Thailand*, ILO/STEP.

# II. Sri Haruethai Klung Credit Union

***Contact:*** *ILO/ STEP Asia focal point*
***Tel:*** *+41-22-799-6544*
***Email:*** *step@ilo.org*

Sri Haruethai Klung Credit Union Co-operatives Ltd. was set up in July 1972 to allow workers in Klung, who are mostly fishermen, to save for unpredictable future needs and to avoid borrowing from loan sharks.

It provides various micro-insurance schemes for its members, which includes:

- **Fire benefit fund**

It covers the actual cost, up to Baht 3,000 for a member and Baht 45,000 for the whole group at any one time. Premiums are paid from the savings and interests generated.

- **Disaster benefit fund**

It covers the actual cost, up to Baht 1,000, of property (including working equipment) owned by the member only. Premiums are paid from the savings and interests generated.

- **Accident benefit fund**

It covers the actual cost, up to Baht 1,000 per member. Premiums are paid from the savings and interests generated.

- **Funeral benefit fund**

A fixed Baht 1,000 payment plus a funeral wreath for the relatives. Premiums are paid from the savings and interests generated.

- **Old age pension fund**

Members over 70 years old will receive 25% increase of their savings subject to a maximum of Baht 5,000. Only members who save at least 400 Baht monthly can participate to the fund.

- **Children's education fund**

20 scholarships of Baht 500 each per year are available for members in need. Premiums are paid from the savings and interests generated.

The following insurance schemes need additional premium payments.

- **Funeral insurance**

To subscribe this insurance, Baht 300 application fee and a montly premium of Baht 100 have to be paid for more than 10 months in a row, in order to be entitled to the benefits payment.

An additional Baht 30 each will be collected among members for the bereaved family when a member dies.

Additional restrictions are:

Only 80% of the benefits will be paid if non-payments occurred 3 times.

Only 70% of the benefits will be paid if non-payments occurred 4 times.

The member will not entitle to any benefits if non-payments occurred 5 times or more.

The waiting period is 6 months.

- **Medical benefit fund**

It functions like a medical savings account in Singapore. To subscribe to the fund, members have to save Baht 30 monthly in a special fund that is only used for medical care. It covers for,

**1. Public hospital care**

Members with 1-6 years membership can enjoy a maximum annual benefits of Baht 500.

Members with more than 6 years membership can enjoy a maximum annual benefits of Baht 600.

For each additional year of membership, Baht 100 will be added to the annual benefits.

Members with more than 30 years membership can enjoy a maximum annual benefits of Baht 3,000.

**2. Childbirth**

At least one year membership with benefits of Baht 500 per birth. Members who do not pay their monthly premium for more than 5 months cannot enjoy the benefits.

**Reference:**

Ponne, I. (1999) *Indigenous Social Protection Schemes, The case of Thailand*, ILO/ STEP.

# Latin America

## Argentina

I. Obra Social Municipal - Municipalidad de Trenque Lauquen

II. Servicio de Salud - Asociación Mutual S.M. Laspiur

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### I. Obra Social Municipal - Municipalidad de Trenque Lauquen

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Municipalidad de Trenque Lauquen

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** Boulevard Villegas 555 (Código Postal 6400) Trenque Lauquen, Provincia de Buenos Aires, Argentina
   ***Telephone:*** **+**54–2392–430 633 / 422 147 / 422 240 / 422 316
   ***Email:*** subcom@tlauquen.mun.gba.gov.ar
   ***Fax:*** **+**54–2392–430 633

3. **Contact person:**
   Dr. Jorge Alberto Barracchia, Municipal administrator

4. **Type of organization responsible for the HMIS:**
   **X** others: Non-profit-making state health care provider

5. **Year (and month) when the scheme was (formally) set up:** May 1992

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** May 1992

7. **Total number of male/female members of the scheme:** 8,999 men and 9,039 women

8. **Total number of members in the organization that has set up the scheme:** Not applicable

9. **Total number of current male/female beneficiaries of the scheme:** 8,999 male and 9,039 female

**10. Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**

**X** If less than 25%, number of beneficiaries excluded or below the poverty line: no information available on numbers

**11. Place of residence for the majority of members:**

**X** rural area: 6%

**X** urban area: 94%

**12. Geographical area covered by the health micro-insurance scheme:**

**X** department: municipality in the interior of the Buenos Aires province

**13. Type of basic health care services covered by the scheme:**

**X** preventive care and health promotion

**X** out-patient care

**X** hospital treatment

**X** midwife services/ reproductive health care

**X** medicines: including medicine for special treatments

**X** medical evacuations: ambulance service for short and long distance

**X** others: laboratory tests, odontology, radiological examination, vaccinations

**14. Method of financing the health insurance:**

**X** members' contributions

**X** voluntary contributions by non-members and other organizations: Invoice to the social security of health

**X** State contribution

**15. Members' participation in the management of the scheme:**

**X** Administration by the organization responsible for the administration of the HMIS without members' participation other than choice of health services covered.

Note: The municipality manages OSMU through a local organization of an elected governmental organ

**16. Technical assistance:** Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

**Information not available**

**-Any bibliographical and written references:**

Strategies and Tools against social Exclusion and Poverty (STEP) Programme, Social Security Department of ILO and Pan American Health Organization (PAHO) joint research.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

Information not available

# II. Servicio de Salud - Asociación Mutual S.M. Laspiur

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Asociación Mutual S.M. Laspiur

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**
**Address:** Avenida 9 de Julio 1, (5943) S.M. Laspiur, Provincia de Córdoba, Argentina
**Telephone:** +54–3533–491 400
**Email:** mutuasml@lasvarillas.com.ar
**Fax:** +54–3533–491 391

**3. Contact person:**
Gustavo Badariotti, Manager (+54-3533-15-688 823 mobile)

**4. Type of organization responsible for the HMIS:**
**X** mutual benefit society

**5. Year (and month) when the scheme was (formally) set up:** November 1990

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** March 1992

**7. Total number of male/female members of the scheme:** 1,800 persons

**8. Total number of members in the organization that has set up the scheme:** 1,800 persons

**9. Total number of current male/ female beneficiaries of the scheme:** approximately 1,800 persons of whom 50.7% female

**10. Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
**X** If less than 25%, number of beneficiaries excluded or below the poverty line: 405 persons

**11. Place of residence for the majority of members:**
**X** rural area: about 25%
**X** urban area: about 75%

**12. Geographical area covered by the health micro-insurance scheme:**
**X** province/region

**13. Type of basic health care services covered by the scheme:**
**X** hospital treatment
**X** midwife services/reproductive health care: 100% for deliveries
**X** others: Nursing care, vaccination

**14. Method of financing the health insurance:**
**X** members' contributions
**X** financial products of the reserves

**X** others: transfers from results of other development activities by Asociación Mutual S.M. Laspiur

**15. Members' participation in the management of the scheme:**

**X** Members' involvement in the organization responsible for the administration of the health micro-insurance scheme

**16. External technical assistance:**

**X** does not receive external technical assistance

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

See case study

**-Any bibliographical and written references:**

A case study was carried out jointly by the STEP (Strategies and Tools against social Exclusion and Poverty) Programme, of the ILO Social Security Department, and PAHO (Pan American Health Organization), 1999. For a copy of the case study, please contact Ms. Victoria Giroud-Castiella. Tel: +41-22-799 6072. Fax: +41-22-799 6644. Email: giroud@ilo.org

**-Names of persons and/or organizations that can provide additional information about the scheme:**

Director of the health establishment Dr. Víctor González, through the same email

For more information, please check http://oitopsmexico99.org.pe

# Bolivia

I. Mutual de Seguro de Salud – CIMES

II. Seguro Universal de Salud del IPTK

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## I. Mutual de Seguro de Salud - CIMES

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Centro Integral de Medicina Social (CIMES)

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**
**Address (state country):** Calle Nataniel Aquirre No. 641, Bolivia
**Telephone:** +591-6-460 444
**Email:** mara.scr@entelnet.bo
**Fax:** +591-6-460 444

**3. Contact person:** Hugo Tomas Loayza Nava

**4. Type of organization responsible for the HMIS:**
**X** mutual benefit society

**5. Year (and month) when the scheme was (formally) set up:** November 1994

**6. Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** November 1994

7. **Total number of male/female members of the scheme:** Information not available

8. **Total number of members in the organization that has set up the scheme:** Information not available

**9. Total number of current male/ female beneficiaries of the scheme:** 10,054 persons by the end of 1998

**10. Proportion of beneficiaries a) excluded from other social security systems or b) with income below the poverty line:**
**X** more than 50%

**11. Place of residence for the majority of members:**
**X** urban surroundings

**12. Geographical area covered by the health micro-insurance scheme:**
**X** commune/village
**X** municipal (City of Sucre, Departamento de Chuquisaca)

**13. Type of basic health care services covered by the scheme:**

- **X** preventive care and health promotion
- **X** out-patient care
- **X** medicines
- **X** other: paediatrics, gynaecology, obstetrics, gastroenterology, cardiology, pneumonia, odontology, ultrasound scan, laboratory tests, nursing.

**14. Method of financing the health insurance:**
- **X** members' contributions
- **X** non-state subsidies from development agencies, donors etc.

**15. Members' participation in the management of the scheme:**
- **X** members' involvement in the organization responsible for the administration of the health micro-insurance scheme

**16. External technical assistance:** Information not available

**17. Other (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
Information not available

**-Any bibliographical and written references:**
Strategies and Tools against social Exclusion and Poverty (STEP) Programme, Social Security Department of ILO and Pan American Health Organization (PAHO) joint research.

**-Names of persons and/or organizations that can provide additional information about the scheme:**
Information not available

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## II. Seguro Universal de Salud - IPTK

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Instituto Politécnico Tomás Katari (IPTK)

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**
***Address:*** Policlínico Tomás Katari. Calle Camargo No. 558. Ciudad de Sucre
***Telephone:*** +591–6–462 447
***Email:*** iptk@mara.scr.entelnet.bo
***Fax:*** +591–6–462 768

**3. Contact person:**
Dr. Gróver Linares Padilla, General director of IPTK

**4. Type of organization responsible for the HMIS:**
- **X** others: NGO

**5. Year (and month) when the scheme was (formally) set up:** March 1996

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** March 1996

7. **Total number of male/female members of the scheme:** 2,027 persons by the end of 1998

8. **Total number of members in the organization that has set up the scheme:** Not applicable

9. **Total number of current male/ female beneficiaries of the scheme:** 2,027 persons by the end of 1998

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    **X** more than 50%

11. **Place of residence for the majority of members:**
    **X** urban surroundings

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** department (Ciudad de Sucre, Ciudad de Potosí and surrounding rural areas in the Departamento de Chuquisaca

13. **Type of basic health care services covered by the scheme:**
    **X** preventive care and health promotion
    **X** out-patient care
    **X** medicines: including medicine for special treatments
    **X** others: Gynaecological-obstetric treatment, laboratory tests, radiological examination, ecography and electrocardiogram diagnostic, odontology, and vaccinations.

14. **Method of financing the health insurance:**
    **X** members' contributions
    **X** non-state subsidies from development agencies, donors etc.
    **X** others: transfers from results of other development activities by IPTK

15. **Members' participation in the management of the scheme:**
    **X** administration by the organization responsible for the administration of the HMIS without members' participation other than choice of health services covered.

16. **External technical assistance:**
    **X** does not receive external technical assistance

17. **Others (if applicable):**
    **-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
    See case study

    **-Any bibliographical and written references:**
    A case study was carried out jointly by the STEP (Strategies and Tools against social Exclusion and Poverty) Programme, of the ILO Social Security Department, and PAHO (Pan

American Health Organization), 1999. For a copy of the case study, please contact Ms. Victoria Giroud-Castiella. Tel: +41-22-799 6072. Fax: +41-22-799 6644. Email: giroud@ilo.org

**-Names of persons and/or organizations that can provide additional information about the scheme:**
General Director of IPTK

For more information, please check http://oitopsmexico99.org.pe

# Colombia

I. Empresa Solidaria de Salud - AMUANDES
II. Empresa Solidaria de salud - COOPSALUD
III. Empresa Solidaria de Salud - ECOMAR
IV. Empresa Solidaria de Salud - ECOOPSALS
V. Empresa Solidaria de Salud - AMAR
VI. Empresa Solidaria de Salud - Co-Esperanza

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## I. Empresa Solidaria de Salud - AMUANDES

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Empresa Solidaria de Salud - AMUANDES

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** Calle 64 sur # 31-15, Barrio Bolivar, Bogotá, Colombia
   ***Telephone:*** +57-1-715 2758, 717 3040, 712 2036
   ***Email:*** maciver@hotmail.com
   ***Fax:*** +57-1-717 3040, 760 0469

3. **Contact person:**
   Miguel Contreras Rivera, Manager

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society
   Note: AMUANDES is registered under Judicial solicitorship No.1559 of 1997 and subscription in the Superintendencia Nacional de Salud is under the Resolution 1593 of August of 1998.

5. **Year (and month) when the scheme was (formally) set up:** August 1998

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** April 1999

7. **Total number of male/ female members of the scheme:** 3,866 persons

8. **Total number of members in the organization that has set up the scheme:** 51 persons

9. **Total number of current male/ female beneficiaries of the scheme:** 3,866 persons

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**

**X** More than 50%: 100%

**11. Place of residence for the majority of members:**

**X** urban surroundings

**12. Geographical area covered by the health micro-insurance scheme:**

**X** department, City of Bogota

Note: AMUANDES wishes to expand its operations to all Santa Fé of Bogota, the capital city of Colombia. The south of Santa Fé of Bogota was initially served by the health insurance. The city is composed of 20 localities, with 31 districts and a population of approximately more than 500.000 people, of which 50% are living in absolute poverty.

**13. Type of basic health care services covered by the scheme:**

**X** preventive care and health promotion: including primary health care

**X** out-patient care (including 2d and 3rd level)

**X** hospital treatment (including 2d and 3rd level)

**X** midwife services/ reproductive health care

**X** medicines including certain medicines for special treatments

**X** other: oral healthcare, imaging diagnostic, clinical laboratory tests, vaccination, radiological examination, as well as owing special reinsurance for illnesses that need expensive treatments (transplant, HIV, cancer, etc.).

**14. Method of financing the health insurance:**

**X** state contribution: Municipality 50%

**X** non-state contributions: 50% from the Guarantee and Solidarity Fund (FOSYGA) which is a statutory fund financed through the "Regimen Contributivo" (Contributive system) financed by employees/employer/self-employed people

**X** Financial products of the reserves

**15. Members' participation in the management of the scheme:**

**X** democratic administration of the scheme by members (general assembly)

**16. External technical assistance:**

**X** Receives permanent technical assistance from District Health Secretariat

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

See case study

**-Any bibliographical and written references:**

A case study was carried out jointly by the STEP (Strategies and Tools against social Exclusion and Poverty) Programme, of the ILO Social Security Department, and PAHO (Pan American Health Organization), 1999. For a copy of the case study, please contact Ms. Victoria Giroud-Castiella. Tel: +41-22-799 6072. Fax: +41-22-799 6644. Email: giroud@ilo.org

**-Names of persons and/or organizations that can provide additional information about the scheme:**

COLACOT, LUIS FRANCISCO VERANO PAEZ, General Secretary

Carrera 25 # 39-94 – Apartado 35940 Bogotá

Tel: +57-1-337 9721, 344 0104
Fax: +57-1-368 1909
Email: colacot@colomsat.net.co – Santafé de Bogotá, Colombia

For more information, please check http://oitopsmexico99.org.pe

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## II. Empresa Solidaria de salud - COOPSALUD

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Centros Cooperativos para la salud - COOPSALUD

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** Carrera 24 # 47-53 Santa Fe de Bogotá, Colombia
   ***Fax:*** +57-1-287 1100

3. **Contact person:**
   José Camilo Franco Nieto, General Manager

4. **Type of organization responsible for the HMIS:**
   **X** co-operative-type organization

5. **Year (and month) when the scheme was (formally) set up:** Information not available

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** April 1999

7. **Total number of male/ female members of the scheme:** 45,000 persons

8. **Total number of members in the organization that has set up the scheme:** Information not available

9. **Total number of current male/ female beneficiaries of the scheme:** 45,000 persons

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    **X** More than 50%: 100%

11. **Place of residence for the majority of members:**
    **X** rural area
    **X** urban surroundings

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** department: The department of Cundinamarca and its capital Santa Fe de Bogotá

13. **Type of basic health care services covered by the scheme:**
    **X** preventive care and health promotion: including primary health care
    **X** out-patient care (including 2d and 3rd level)
    **X** hospital treatment (including 2d and 3rd level)
    **X** midwife services/ reproductive health care

- **X** medicines including certain medicines for special treatments
- **X** other: oral healthcare, imaging diagnostic, clinical laboratory tests, vaccination, radiological examination, as well as owing special reinsurance for illnesses that need expensive treatments (transplant, HIV, cancer, etc.).

**14. Method of financing the health insurance:**

- **X** state contribution: Municipality 50%
- **X** non-state contributions: 50% from the Guarantee and Solidarity Fund (FOSYGA) which is a statutory fund financed through the "Regimen Contributivo" (Contributive system) financed by employees/employer/self-employed people
- **X** Financial products of the reserves

**15. Members' participation in the management of the scheme:**

- **X** administration by the organization responsible for the administration of the HMIS with members' participation other than health services covered

**16. External technical assistance:** Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

The operation of the scheme is efficient and continues to improve. The administration and performance of the institution assures its health insurance scheme continues to be viable in its expansion programme. Interest in the health insurance scheme exists among the affiliated organizations, from the users to the medical personnel.

**-Any bibliographical and written references:**

Crisis de la Salud y el Rol de los Sistemas Solidarios y Mutualistas en América Latina (The health crisis and the list of the solidarity and mutual schemes in Latin America), Santa Fe de Bogotá 1995. Page 111 to 113.

Strategies and Tools against social Exclusion and Poverty (STEP) Programme, Social Security Department of ILO and Pan American Health Organization (PAHO) joint research.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

COODESA: Cooperativa de Salud y Trabajo Asociado, Carrera 24 No 47-53, Santafé de Bogotá, Colombia

Fax: +57-1-287 1100

# III. Empresa Solidaria de Salud - ECOMAR

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Empresa Cooperativa de Servicios Múltiples de la Argentina -ECOMAR

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** Carrera 6 # 6-49 la Argentina, Departamento del Huila, Colombia
   ***Telephone:*** +57-988–311 685

3. **Contact person:**
   Duber Antonio Sánchez Jiménez, Manager and Legal Representative

4. **Type of organization responsible for the HMIS:**
   **X** co-operative-type organization
   **X** health care provider: Institución prestadora del servicio de salud (IPS)

5. **Year (and month) when the scheme was (formally) set up:** Information not available

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** October 1998

7. **Total number of male/ female members of the scheme:** Information not available

8. **Total number of members in the organization that has set up the scheme:** Information not available

9. **Total number of current male/ female beneficiaries of the scheme:**

| | | |
|---|---|---|
| Rural area general population: | male: 2,259 | female: 2,316 |
| Rural area indigenous people: | male: 103 | female: 53 |
| Urban area: | male: 539 | female: 505 |

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    **X** More than 50%: 100%

11. **Place of residence for the majority of members:**
    **X** rural area
    **X** urban area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** department: Municipio de la Argentina, Departamento del Huila

13. **Type of basic health care services covered by the scheme:**
    **X** preventive care and health promotion: including primary health care
    **X** out-patient care (including 2d and 3rd level)
    **X** hospital treatment (including 2d and 3rd level)
    **X** midwife services/ reproductive health care
    **X** medicines including certain medicines for special treatments

**X** other: oral healthcare, imaging diagnostic, clinical laboratory tests, vaccination, radiological examination, as well as owing special reinsurance for illnesses that need expensive treatments (transplant, HIV, cancer, etc.).

**14. Method of financing the health insurance:**

**X** state contribution: Municipality 50%

**X** non-state contributions: 50% from the Guarantee and Solidarity Fund (FOSYGA) which is a statutory fund financed through the "Regimen Contributivo" (Contributive system) financed by employees/employer/self-employed people

**X** Financial products of the reserves

**15. Members' participation in the management of the scheme:**

**X** democratic administration of the scheme by members (general assembly)

**16. External technical assistance:** Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

The health insurance scheme has brought benefits to the community, reaching out to the poor and vulnerable in the community in the areas where most people have never had access to health services, and the opportunity to improve their health and raise their quality of life. The community has thus, expressed satisfaction with the performance of the company in general and in the health insurance programme in particular.

Since more than 90% of the local health services are subsidised by the national social security system, 85% of the premium collected can be allotted to serve health needs, and only 15% is used for operation expenses.

**-Any bibliographical and written references:**

COLOMBIA. MINISTERIO DE SALUD. Primer encuentro nacional de empresas solidarias de salud. Bogotá. 1996.

JARAMILLO, I. El futuro de la salud en Colombia. Bogotá, FESCOL, 1994

COLACOT. Crisis de la salud y el rol de los sistemas solidarios y mutualistas en América Latina.

Strategies and Tools against social Exclusion and Poverty (STEP) Programme, Social Security Department of ILO and Pan American Health Organization (PAHO) joint research.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

Ministerio de Salud (Ministry of Health), Santafé de Bogotá, Colombia

Tel: +57-1-336 5066

COLACOT, Santafé de Bogotá, Colombia

Tel: +57-1-337 9721 and 344 0104

ECOMAR

Duber Sánchez, La Argentina, Huila, Colombia

Tel: +57-1-988-311 561

# IV. Empresa Solidaria de Salud - ECOOPSALS

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Empresa Cooperativa Solidaria en Salud - ECOOPSALS

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** Sede Principal: Calle 30 sur No. 12-10 este Barrio Ramajal, Santa Fé, Bogotá, Colombia
   ***Telephone:*** +57-1-366 0840, 239 5089, 367 8532
   ***Fax:*** +57-1-366 0843, 364 2473

3. **Contact person:**
   Argemiro Rincón, Manager

4. **Type of organization responsible for the HMIS:**
   **X** co-operative-type organization: Empresa Solidaria de Salud – Administradora del Régimen Subsidiado

5. **Year (and month) when the scheme was (formally) set up:** Information not available

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** June 1996

7. **Total number of male/ female members of the scheme:** Information not available

8. **Total number of members in the organization that has set up the scheme:** Information not available

9. **Total number of current male/ female beneficiaries of the scheme:** 31,292 male and 32,108 female

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    **X** More than 50%: 100%

11. **Place of residence for the majority of members:**
    **X** urban surroundings

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** department: Peripheral zone on the east side of Santa Fé of Bogota

13. **Type of basic health care services covered by the scheme:**
    **X** preventive care and health promotion: including primary health care
    **X** out-patient care (including 2d and 3rd level)
    **X** hospital treatment (including 2d and 3rd level)
    **X** midwife services/ reproductive health care
    **X** medicines including certain medicines for special treatments
    **X** other: oral healthcare, imaging diagnostic, clinical laboratory tests, vaccination, radiological examination, as well as owing special reinsurance for illnesses that need expensive treatments (transplant, HIV, cancer, etc.).

**14. Method of financing the health insurance:**

**X** state contribution: Municipality 50%

**X** non-state contributions: 50% from the Guarantee and Solidarity Fund (FOSYGA) which is a statutory fund financed through the "Regimen Contributivo" (Contributive system) financed by employees/employer/self-employed people

**X** financial products of the reserves

**15. Members' participation in the management of the scheme:**

**X** democratic administration of the scheme by members (general assembly)

**16. External technical assistance:** Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

The subsidised scheme is the result of a political agenda and subsidy allocation to the health sector. The beneficiaries of the scheme were selected through a survey and were asked to choose the insuring organization. This method of selection improves the quality of care service since public organizations compete with private and mutual associations. In this way, it has given poor people greater access to the health services.

**-Any bibliographical and written references:**

COLOMBIA. MINISTERIO DE SALUD. Primer encuentro nacional de empresas solidarias de salud. Bogotá. 1996

COLOMBIA. MINISTERIO DE SALUD. La reforma a la seguridad social en salud. Bogotá, 1994.

JARAMILLO, I. El futuro de la salud en Colombia. Bogotá, FESCOL, 1994.

Strategies and Tools against social Exclusion and Poverty (STEP) Programme, Social Security Department of ILO and Pan American Health Organization (PAHO) joint research.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

| | |
|---|---|
| Secretaria de Salud de Santafé de Bogotá: | +57-1-310 1111 |
| Superintendencia Nacional de salud: | +57-1-336 4600 |
| Ministerio de Salud: | +57-1-336 5066 |
| Confederación de Empresas solidarias de salud: | +57-1-323 1750 |

# V. Empresa Solidaria de Salud - AMAR

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Asociación Mutual de la Argentina - AMAR

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** Carrera 4 # 3, 46 Brisas de la Argentina, Departamento del Huila, Colombia
   ***Telephone:*** +57-988-311 685
   ***Fax:*** +57-988-311 685

3. **Contact person:**
   Jair Alberto Vargas Rojas, Manager, Legal Representative

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up:** Information not available

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** September 1996

7. **Total number of male/ female members of the scheme:** Information not available

8. **Total number of members in the organization that has set up the scheme:** Information not available

9. **Total number of current male/ female beneficiaries of the scheme:**

| | | |
|---|---|---|
| Rural area general population: | male: 2,259 | female: 2,316 |
| Rural indigenous people: | male: 103 | female: 53 |
| Urban area: | male: 539 | female: 505 |

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    **X** More than 50%

11. **Place of residence for the majority of members:**
    **X** rural area
    **X** urban area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** department: Municipio de la Argentina, Departamento del Huila

13. **Type of basic health care services covered by the scheme:**
    **X** preventive care and health promotion: including primary health care
    **X** out-patient care (including 2d and 3rd level)
    **X** hospital treatment (including 2d and 3rd level)
    **X** midwife services/ reproductive health care
    **X** medicines including certain medicines for special treatments

**X** other: oral healthcare, imaging diagnostic, clinical laboratory tests, vaccination, radiological examination, as well as owing special reinsurance for illnesses that need expensive treatments (transplant, HIV, cancer, etc.).

**14. Method of financing the health insurance:**

**X** state contribution: Municipality 50%

**X** non-state contributions: 50% from the Guarantee and Solidarity Fund (FOSYGA) which is a statutory fund financed through the "Regimen Contributivo" (Contributive system) financed by employees/employer/self-employed people

**X** Financial products of the reserves

**15. Members' participation in the management of the scheme:**

**X** democratic administration of the scheme by members (general assembly)

**16. External technical assistance:** Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

The co-operative is looking to provide opportunities for everyone, especially for school drop-outs, so they could contribute to the development of their local communities, particularly in the area of health service as well as in the life and working conditions of the community.

**-Any bibliographical and written references:**

Strategies and Tools against social Exclusion and Poverty (STEP) Programme, Social Security Department of ILO and Pan American Health Organization (PAHO) joint research.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

COLACOT: Santafé de Bogotá. Tel: +57-1-337 9721 and 344 0104

AMAR-ESS: JAIR SANCHEZ. La Argentina, Huila, Colombia. Tel: +57-1-988-311685

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# VI. Empresa Solidaria de Salud - Co-Esperanza

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Cooperativa especializada de salud la Esperanza Sogamoso Ltda - Co-Esperanza.

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**
**Address (state country):** Sede Social, Calle 8 No. 11-53, Ciudad de Sogamoso, Departamento de Boyacá, República de Colombia.
**Telephone:** +57-987-771 2874 and 772 2978
**Fax:** +57-987-770 2355

**3. Contact person:** Zulema Barrera, manager

**4. Type of organization responsible for the HMIS:**

**X** co-operative-type organization

5. **Year (and month) when the scheme was (formally) set up:** May 1995

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** October 1995

7. **Total number of male/female members of the scheme:** 42,056 persons

8. **Total number of members in the organization that has set up the scheme:** 1,176 persons

9. **Total number of current male/ female beneficiaries of the scheme:** 21,922 female and 20,078 male, and 56 with no information. Out of a total of 42,056, 37,260 live in Boyacá and 4,796 live in Bogotá

10. **Proportion of beneficiaries a) excluded from other social security systems or b) with income below the poverty line:**
    **X** more than 50%: 100%

11. **Place of residence for the majority of members:**
    **X** rural area: 33% live in the rural area of Boyacá
    **X** urban area: 56% live in the urban area of Bayacá
    **X** urban surrounding: 11% live in the urban surrounding of Bogotá

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** province/region: Co-esperanza works in both rural and urban areas, mainly in the Departamento de Boyacá.

13. **Type of basic health care services covered by the scheme:**
    **X** preventive care and health promotion: including primary health care
    **X** out-patient care (including 2d and 3rd level)
    **X** hospital treatment (including 2d and 3rd level)
    **X** midwife services/ reproductive health care
    **X** medicines: including certain medicines for special treatments
    **X** other: oral healthcare, imaging diagnostic, clinical laboratory tests, vaccination, radiological examination, as well as owing special reinsurance for illnesses that need expensive treatments (transplant, HIV, cancer, etc.).

14. **Method of financing the health insurance:**
    **X** state contribution: Municipality 50%
    **X** non-state contributions: 50% from the Guarantee and Solidarity Fund (FOSYGA) which is a statutory fund financed through the "Regimen Contributivo" (Contributive system) financed by employees/employer/self-employed people
    **X** Financial products of the reserves

15. **Members' participation in the management of the scheme:**
    **X** members' involvement in the organization responsible for the administration of the Micro Health Insurance Scheme

16. **Technical assistance:**
    **X** receives external technical assistance as required

**17. Other (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

See case study

**-Any bibliographical and written references:**

Jaramillo Pérez, Iván*. El Futuro de la Salud en Colombia - Ley 100 de 1993 , cinco años despues* - Publicación de FESCOL, FRB, FES, FUNDACION CORONA, Santafé de Bogotá, cuarta edición Enero de 1999.

Jaramillo Pérez, Iván, Elizabeth Suárez *La Aplicación de la ley 100 a la Salud de Bogotá*, El Caso del Silos de Usaquén.. " ,Fundación Corona 1995.

*Ley Cien, Cuatro Años de implementación,* ASSALUD, CORONA, FES, FESCOL, GTZ, Bogotá, Septiembre de 1998.

*Régimen Contributivo, Régimen Subsidiado, Actualización a Noviembre de 1996*, en Ley Cien, Un Año de implementación, Fundación FES, ASSALUD, Bogotá, Agosto de 1997.

*Recomendaciones for aplicar la ley 100 a la Salud de Bogotá*, en "Transformar Ciudad con ciudadanía", Consejo Territorial de Planeación de Santafé de Bogotá 1995.

A case study was carried out jointly by the STEP (Strategies and Tools against social Exclusion and Poverty) Programme, of the ILO Social Security Department, and PAHO (Pan American Health Organization), 1999. For a copy of the case study, please contact Ms. Victoria Giroud-Castiella. Tel: +41-22-799 6072. Fax: +41-22-799 6644. Email: giroud@ilo.org

**-Names of persons and/or organizations that can provide additional information about the scheme:**

ASSALUD - Asociación Colombiana de la Salud.

Ministerio de Salud de Colombia. Dirección de Seguridad Social.

Secretaria Departamental de Salud de Boyaca. Dirección de Seguridad Social.

For more information, please check http://oitopsmexico99.org.pe

# Dominican Republic

I. Seguro para servicio de consultas fijas y ambulatorias - Asociación Mutual de los Trabajadores de los Bateyes - AMUTRABA

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## I. Seguro para servicio de consultas fijas y ambulatorias - Asociación Mutual de los Trabajadores de los Bateyes (AMUTRABA)

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Movimiento Sociocultural de los trabajadores Haitianos 'MOSCTHA'.

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** Calle Juan Erazo No. 39 Villa Juana, Santo Domingo, Repúlica Dominicana
   ***Telephone:*** +1809-687 2318
   ***Email:*** mosctha@codetel.net.do
   ***Fax:*** +1809-221 8371

3. **Contact person:**
   Joseph Cherubim, President

4. **Type of organization responsible for the HMIS:**
   **X** mutual benefit society

5. **Year (and month) when the scheme was (formally) set up:** October 1995

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** October 1995

7. **Total number of male/female members of the scheme:** 259 women and 251 men

8. **Total number of members in the organization that has set up the scheme:** 8,789 persons

9. **Total number of current male/ female beneficiaries of the scheme:** approximately 2,500 persons

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    **X** More than 50%: 99%

11. **Place of residence for the majority of members:**
    **X** rural area
    **X** urban surroundings

**12. Geographical area covered by the health micro-insurance scheme:**

**X** province/ region: Bateyes del Ingenio Río Haina, Ingenio Ozama and Boca Chica and several towns surrounding the capital

**13. Type of basic health care services covered by the scheme:**

**X** preventive care and health promotion
**X** out-patient care
**X** hospital treatment
**X** midwife services/ reproductive health care
**X** medicines
**X** others: family planning, odontology, basic laboratory tests, radiological examination, ambulance service and managing the utilisation of public hospital services.

**14. Method of financing the health insurance:**

**X** members' contributions: $RD 10
**X** state contribution
**X** non-state subsidies from development agencies, donors etc.: donations from UNAIDS, World Solidarity Programme, the Church
**X** others: transfers of results from other development activities by MOSCTHA

**15. Members' participation in the management of the scheme:**

**X** democratic administration of the scheme by members (general assembly)

**16. External technical assistance:**

**X** receives external technical assistance as required

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
See case study

**-Any bibliographical and written references:**
MOSCTHA, AMUTRABA. Revista memoria de actividades 1997 – 1998.

PINZON R, Julio Alberto: Diagnóstico y Plan de desarrollo 1999-2003, COLACOT, Santa Fé de Bogotá, 1998

A case study was carried out jointly by the STEP (Strategies and Tools against social Exclusion and Poverty) Programme, of the ILO Social Security Department, and PAHO (Pan American Health Organization), 1999. For a copy of the case study, please contact Ms. Victoria Giroud-Castiella. Tel: +41-22-799 6072. Fax: +41-22-799 6644. Email: giroud@ilo.org

**-Names of persons and/or organizations that can provide additional information about the scheme:**
NATALIO PEREZ GARCIA: Gerente Juan Erazo # 39 Apartado Postal 309 Santo Domingo, República Dominicana.
Tel: +1809-687 2318
FAX: 1+809-221 8371
For more information, please check http://oitopsmexico99.org.pe

# Ecuador

I. Seguro Comunitario SOLANO – Comité de salud del subcentro de Salud Solano

II. Seguro Familiar - FEPP

III. Seguro Social Popular - Sistema Comunitario de Salud Integral (SICSI)

IV. Sistema Solidario de Asistencia Médica – Salud Mutual

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## I. Seguro Comunitario SOLANO – Comité de salud del subcentro de Salud Solano

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Comité de salud del Subcentro de Salud de Solano, provincia de Cañar

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** Dr. Francois Brédo, casilla postal 03-01-766, Azogues, Ecuador
   ***Telephone:*** +593-7-243 288
   ***Email:*** aps2@c.pas.org.ec
   ***Fax:*** +593-2-509 765 (Pierre Paepe)

3. **Contact person:**
   Dr. Fausto Maldonado, Azogues Area Coordinator
   Email: apsaz@c.aps.org.ec

4. **Type of organization responsible for the HMIS:**
   **X** other community organization

5. **Year (and month) when the scheme was (formally) set up:** December 1997

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** March 1998

7. **Total number of male/female members of the scheme:** 143 women and 93 men

8. **Total number of members in the organization that has set up the scheme:** Not applicable

9. **Total number of current male/ female beneficiaries of the scheme:** 143 female and 93 male

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    **X** more than 50%

**11. Place of residence for the majority of members:**

**X** rural area: approximately 100%

**12. Geographical area covered by the health micro-insurance scheme:**

**X** commune/village: Solano rural community with a total population of 1,300 people

**13. Type of basic health care services covered by the scheme:**

**X** preventive care and health promotion: primary health care

**X** outpatient care

**X** hospital treatment

**X** midwife services/ reproductive health care: gynaecological-obstetrical treatment

**X** medicines: including medicines for special treatments

**X** others: primary level of odontology, laboratory tests, radiological examination, vaccination.

**14. Method of financing the health insurance:**

**X** members' contributions

**X** State contribution (part of the Ministry of Public Health service)

**X** non-state subsidies from development agencies, donors etc.

**15. Members' participation in the management of the scheme:**

**X** administration by the organization responsible for the administration of the MHIS without members' participation other than choice of health services covered.

**16. External technical assistance:**

**X** receives regular external technical assistance (for APS project from 1996)

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

See case study

**-Any bibliographical and written references:**

A case study was carried out jointly by the STEP (Strategies and Tools against social Exclusion and Poverty) Programme, of the ILO Social Security Department, and PAHO (Pan American Health Organization), 1999. For a copy of the case study, please contact Ms. Victoria Giroud-Castiella. Tel: +41-22-799 6072. Fax: +41-22-799 6644. Email: giroud@ilo.org

**-Names of persons and/or organizations that can provide additional information about the scheme:**

Dr. Fausro Maldonado, Dr. Francois Brédo or Dr. Pierre de Paepe

For more information, please check http://oitopsmexico99.org.pe

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## II. Seguro Familiar - FEPP

**1. Name of the organization responsible for the HMIS or its owner**

**(if the ownership is legally defined):** Fondo Ecuatoriano Populorum Progreso (FEPP)

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** Mallorca 427 y Coruna, Quito, Ecuador
   ***Telephone:*** +593-2-520 408
   ***Email:*** fepp@uio.satnet.net
   ***Fax:*** +593-2-504 978

3. **Contact person:**
   Mario Cadena, Sub Director

4. **Type of organization responsible for the HMIS:**
   **X** non-profit health care provider

5. **Year (and month) when the scheme was (formally) set up:** Information not available

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** Information not available

7. **Total number of male/female members of the scheme:** Information not available

8. **Total number of members in the organization that has set up the scheme:** Information not available

9. **Total number of current male/ female beneficiaries of the scheme:** 70 female and 170 male with their families

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    **X** If less than 25%, number of beneficiaries excluded or below the poverty line: 20%

11. **Place of residence for the majority of members:**
    **X** rural area
    **X** urban area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** national

13. **Type of basic health care services covered by the scheme:**
    **X** preventive care and health promotion
    **X** outpatient care
    **X** hospital treatment
    **X** medicines
    **X** midwife services

14. **Method of financing the health insurance:**
    **X** members' contributions
    **X** others: Employers' contribution

15. **Members' participation in the management of the scheme:**
    **X** democratic administration of the scheme by members (general assembly)

16. **External technical assistance:** Information not available

17. **Others (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
The scheme began with a particular type of insurance that was contracted by the directors of the organization. After a year, the organization was advised to change its health insurance scheme. Thus, the birth of its very own family insurance programme.

This new family insurance package is offered by the institution as an alternative to the regular HMIS for the security and protection it offers to its workers. A similar scheme will also be implemented in a year and a half's time.

The scheme classifies the HMIS subscribers according to various health care packages. It offers 3 types: one for the single, another for the married and still another for married with family, with each paying varying levels of contribution. A limit has been set for each claim between S.10,000,000 and S.60,000,000.

The scheme is open to the members of the workforce who believe in the viability of this insurance scheme and in what it has to offer to its would-be subscribers.

Aside from the security and protection offered by this voluntary insurance scheme, it also strengthens the right of each member to a better quality of life with the long-term savings placements that will cover family emergencies in the future.

**-Any bibliographical and written references:**
Strategies and Tools against social Exclusion and Poverty (STEP) Programme, Social Security Department of ILO and Pan American Health Organization (PAHO) joint research.

**-Names of persons and/or organizations that can provide additional information about the scheme:**
Norma Hutmacher, Quito, Ecuador
Tel: +593-2-544 201

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# III. Seguro Social Popular – Sistema Comunitario de Salud Integral (SICSI)

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** The security is a collaboration between 4 parties, namely the Ministry of Public Health (Ministerio de Salud Pública, MSP), the Association of Solidarity and Action (Asociación Solidaridad y Acción, ASA), the Barrio Colinas del Norte, and the Homeopathic Medical Society.

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
***Address:*** c/o Francisco Sanchez 82-13 y Miguel de la Rosa, Carcelén, Quito, Pichincha, Ecuador
***Telephone:*** +593-2-472 999/ 485 072
***Email:*** kito@pi.pro.ec / asosolac@uio.satnet.net
***Fax:*** +593-2-485 073

3. **Contact person:**
Dr. Julio Gómez Canedo (Physician), Manager of the health area of ASA

4. **Type of organization responsible for the HMIS:**
   - **X** association
   - **X** non-profit health care provider
   - **X** others: Ministry of Public Health

5. **Year (and month) when the scheme was (formally) set up:** December 1998

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** April 1999

7. **Total number of male/female members of the scheme:** Information not available

8. **Total number of members in the organization that has set up the scheme:** Information not available

9. **Total number of current male/ female beneficiaries of the scheme:** approximately 2,000 families, representing some 50% of the member community

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    - **X** More than 50%

    Note: 76% of the inhabitants of the community have been receiving the "Bono Solidario" (Solidarity Bond) which was revived by the government of the Republic in September 1998. This bond is for families with a monthly income of less than a million sucres (the cost of a basket of basic goods for a family is on average two million).

11. **Place of residence for the majority of members:**
    - **X** urban surroundings

12. **Geographical area covered by the health micro-insurance scheme:**
    - **X** commune/village

    Note: The insurance installs in the city of Quito, in the neighbourhood called Colinas del Norte. It is a neighbourhood with urban characteristics located in the North of Quito. One foresees extension of the geographical coverage to other neighbourhoods of the city.

13. **Type of basic health care services covered by the scheme:**
    - **X** preventive care and health promotion
    - **X** outpatient care
    - **X** hospital treatment
    - **X** medicines
    - **X** midwife services
    - **X** others: Specialised and homeopathic treatments

14. **Method of financing the health insurance:**
    - **X** members' contributions
    - **X** state contribution
    - **X** non-state subsidies from development agencies, donors etc.

15. **Members' participation in the management of the scheme:**

**X** administration by the organization responsible for the administration of the HMIS with members' participation other than choice of health services covered.

**16. External technical assistance:** Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

The Seguro Social Popular (SSP) supports the SICSI system that ensures the poorer population in the city's slum has access to health services. The Ministry of Public Health has the constitutional responsibility in guaranteeing the right of poor communities to health services. Non-governmental organizations, on the other hand, continue to mobilise themselves to correct the situation where this right is violated. SSP allows the channelling of funds from the Ministry, the NGOs, and members' contributions to implement a medical insurance programme. It also shows a different management style and a progressive investment in health.

On the socio-cultural aspect, the scheme contributes to a positive change of the marginalised urban sector, whose members spend proportionately more of their income on important health care services.

**-Any bibliographical and written references:**

Strategies and Tools against social Exclusion and Poverty (STEP) Programme, Social Security Department of ILO and Pan American Health Organization (PAHO) joint research.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

Dr. Jorge Albán, Director Nacional de Areas de Salud (National Health Director). Tel: +593-2-546 250

Ldo. Cesar Rodriguez. Dirigente Comunidad Colinas del Norte (Northern Cities Community Manager) Tel: +593-2-493 799

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# IV. Sistema Solidario de Asistencia Médica – Salud Mutual

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Cooperativa de servicios de asistencia médica 'Salud Mutual'

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**
***Address:*** Francisco de Olmos # 520 Quito, Ecuador
***Telephone:*** +593-2-660 652
***Fax:*** +593-2-660 652

**3. Contact person:**
***Name:*** Guillermo Silva, President
***Address:*** Médico Comunitario

**4. Type of organization responsible for the HMIS:**

**X** co-operative-type organization

5. **Year (and month) when the scheme was (formally) set up:** Information not available

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** January 2000

7. **Total number of male/female members of the scheme:** Information not available

8. **Total number of members in the organization that has set up the scheme:** Information not available

9. **Total number of current male/ female beneficiaries of the scheme:** 5,000 persons

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    **X** More than 50%: 90%

11. **Place of residence for the majority of members:**
    **X** rural area
    **X** urban surroundings

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** province/region: Cantón de Quito and Provincia de Pichincha

13. **Type of basic health care services covered by the scheme:**
    **X** preventive care and health promotion

14. **Method of financing the health insurance:**
    **X** members' contributions: 95%
    **X** voluntary contributions by non-members and other organizations

15. **Members' participation in the management of the scheme:**
    **X** democratic administration of the scheme by members (general assembly)

16. **External technical assistance:** Information not available

17. **Others (if applicable):**
    **-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
    The mutual health scheme has implemented various health care services, and at the same time, abided by the laws governing the administration of health services. The scheme will remain to be viable as long as funds are available for its operation. Interest in the programme is sustained among those who are involved in the scheme, ranging from the medical personnel who administer the various health services, to the insurance subscribers who are covered by the HMIS.

    **-Any bibliographical and written references:**
    SILVA, Guillermo: Diagnóstico de la situación de la salud en Ecuador, presentado al Seminario – taller de promoción. Quito, May 1998

    PINZON R, Julio Alberto: Diseno Técnico y económico para la organización y puesta en funcionamiento de la Cooperativa de servicios mutuales. COLACOT, September 1998

Strategies and Tools against social Exclusion and Poverty (STEP) Programme, Social Security Department of ILO and Pan American Health Organization (PAHO) joint research.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

Treasurer of the health co-operative.

Francisco Olmos # 520 y ALPAHUASI REDOMA DE CHAGUARQUINGO APARTADO 17 02 5227, Quito, Ecuador

Tel: +593-2-660 652

# Guatemala

I. Servicio Solidario de Salud - CGTG

II. Convenio Familiar de Salud - ASSABA

III. Fondo de Solidaridad Social - ACSMI

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## I. Servicio Solidario de Salud - CGTG

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Central General de Trabajadores de Guatemala (CGTG)

2. **Address of the HMIS Head Office (or contact address of the responsible organization):** ***Address:*** 3a Ave., 12-22, zona 1, Ciudad de Guatemala, Guatemala

3. **Contact person:** Pinzon

4. **Type of organization responsible for the HMIS:**
   **X** non-profit making civil association

5. **Year (and month) when the scheme was (formally) set up:** July 1996

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** July 1996

7. **Total number of male/female members of the scheme:** 948 members of which around 40% are women

8. **Total number of members in the organization that has set up the scheme:** 16,482 persons

9. **Total number of current male/ female beneficiaries of the scheme:** around 4,740 persons

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    **X** More than 50%: (estimated 72.44% of members have income below the poverty line)

11. **Place of residence for the majority of members:**
    **X** urban area: about 3%
    **X** urban surroundings: about 97%

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** department: the central and surrounding areas of Guatemala City

13. **Type of basic health care services covered by the scheme:**
    **X** out-patient care

**X** medicines
**X** others: laboratory tests

**14. Method of financing the health insurance:**
**X** members' contributions
**X** others: transfers of results from other development activities of CGTG and common fund of CGTG to cover any deficit incurred by the scheme

**15. Members' participation in the management of the scheme:**
**X** administration by the organization responsible for the administration of the MHIS without members' participation other than choice of health services covered.

**16. External technical assistance:**
**X** does not receive external technical assistance

**17. Others (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
See case study

**-Any bibliographical and written references:**
A case study was carried out jointly by the STEP (Strategies and Tools against social Exclusion and Poverty) Programme, of the ILO Social Security Department, and PAHO (Pan American Health Organization), 1999. For a copy of the case study, please contact Ms. Victoria Giroud-Castiella. Tel: +41-22-799 6072. Fax: +41-22-799 6644. Email: giroud@ilo.org

**-Names of persons and/or organizations that can provide additional information about the scheme:**
COLACOT and CESAL

For more information, please check http://oitopsmexico99.org.pe

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## II. Convenio Familiar de Salud - ASSABA

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Asociación para la Salud de Barillas (ASSABA)

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**
**Address (state country):** Municipio de Barillas de Departamento de Huehuetenango
**Telephone:** None
**Email:** None
**Fax:** None

**3. Contact person:** Sr. Gregorio Filemón Gordillo Méndez, President of Executive Committee of ASSABA

**4. Type of organization responsible for the HMIS:**
**X** association

5. **Year (and month) when the scheme was (formally) set up:** Information not available

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** July 1997

7. **Total number of male/female members of the scheme:** Information not available

8. **Total number of members in the organization that has set up the scheme:** Information not available

9. **Total number of current male/ female beneficiaries of the scheme:** 1,000 pregnant women

10. **Proportion of beneficiaries a) excluded from other social security systems or b) with income below the poverty line:**
    **X** more than 50%

11. **Place of residence for the majority of members:**
    **X** rural area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** municipal

13. **Type of basic health care services covered by the scheme:**
    **X** preventive care and health promotion
    **X** hospital treatment
    **X** midwife services/ reproductive health care

14. **Method of financing the health insurance:**
    **X** members' contributions
    **X** non-state subsidies from development agencies, donors etc.
    **X** other: Fondos Semilla

15. **Members' participation in the management of the scheme:**
    **X** Administration by the organization responsible for the administration of the HMIS with members' participation other than choice of health services covered.

16. **Technical assistance:** Information not available

17. **Other (if applicable):**
    **-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
    The municipal of Barillas is a highly marginalised area, with indigenous population. The nearest hospital situated at 153 Km away, which will take 10 hours to reach there.

    **-Any bibliographical and written references:**
    SIMAS- Sistema Municipal de Salud

    Propuesta Convenio Familiar en Salud de Barillas

    Agreement between MSPAS and ASSABA

    Contract of OPS/OMS and ASSABA

Strategies and Tools against social Exclusion and Poverty (STEP) Programme, Social Security Department of ILO and Pan American Health Organization (PAHO) joint research.

**-Names of persons and/or organizations that can provide additional information about the scheme:**
Director Centro de Salud, Alcalde Municipal, OPS/OMS PWR GUT.

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## III. Fondo de Solidaridad Social - ACSMI

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Asociación Coordinadora de Salud de Municipio de Ixcán (ACSMI)

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
**Address (state country):** Aldea Cantabal, Municipio Ixcán del Departamento del Quiché
**Telephone:** ACSMI does not have telephone. The office telephone of OPS/OMS at Ixcán is +502-951-3313
**Email:** ACSMI does not have email. The email of OPS/OMS at Ixcán is **ctdixc@ops.org.gt**
**Fax:** ACSMI does not have fax. The office fax number of OPS/OMS at Ixcán is +502-951-3313

3. **Contact person:** Sr. Gerardo Casimiro Guerra, President of the Executive board of ACSMI

4. **Type of organization responsible for the HMIS:**
**X** other community organization

5. **Year (and month) when the scheme was (formally) set up:** Information not available

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** Information not available

7. **Total number of male/female members of the scheme:** Information not available

8. **Total number of members in the organization that has set up the scheme:** Information not available

9. **Total number of current male/ female beneficiaries of the scheme:**

| | |
|---|---|
| Children of 5 years and more | 6,140 |
| Students | 2,790 |
| Fertile women | 8,372 |
| Expecting pregnancy | 2,790 |
| Pregnancy with complication | 140 |

10. **Proportion of beneficiaries a) excluded from other social security systems or b) with income below the poverty line:**
**X** more than 50%

11. **Place of residence for the majority of members:**
**X** rural area

**12. Geographical area covered by the health micro-insurance scheme:**

**X** commune/village

**13. Type of basic health care services covered by the scheme:**

**X** preventive care and health promotion

**X** midwife services/ reproductive health care

**X** medical evacuations: Transportation service to the nearest health centre.

**14. Method of financing the health insurance:**

**X** members' contributions

**X** non-state subsidies from development agencies, donors etc.: NGO

**15. Members' participation in the management of the scheme:**

**X** Administration by the organization responsible for the administration of the HMIS with members' participation other than choice of health services covered.

**16. Technical assistance:** Information not available

**17. Other (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

The municipal of Ixcán is located in the north of Departamento del Quiché, a remote indigenous zone, which is now a war zone. The scheme was initiated by a development plan of Fondo de Solaridad in 1993. The nearest hospital is 12 hours away from Cantabla, which is the most important municipality in the area.

**-Any bibliographical and written references:**

Documentos de propuestas del Fondo Solidaridad y Convenio Familiar en Salud de la OPS/OMS PWR GT

Strategies and Tools against social Exclusion and Poverty (STEP) Programme, Social Security Department of ILO and Pan American Health Organization (PAHO) joint research.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

Jefatura del Area de Salud de Ixcán – MSPAS

Oficina de OPS/OMS de Ixcán

# Nicaragua

I. Seguro de Salud Universal - ATC

## I. Seguro de Salud Universal - ATC

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Asociación Mutua del Campo (ATC)

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** Barrio El Progreso, de ESSO Calero 50 varas al oeste, Matagalpa, Nicaragua
   ***Telephone:*** +505-612 5237
   ***Fax:*** +505-612 5237

3. **Contact person:** Carlos Alvarado and Fausto Torres Arauz, Poverty adviser and President of the Board of Directors of the Association

4. **Type of organization responsible for the HMIS:**
   **X** non-profit making civil association

5. **Year (and month) when the scheme was (formally) set up:** September 1995

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** September 1995

7. **Total number of male/female members of the scheme:** 1,125 persons by May 1999 of which around 40% are women

8. **Total number of members in the organization that has set up the scheme:** 1,125 persons

9. **Total number of current male/ female beneficiaries of the scheme:** approximately 5,625 beneficiaries by May 1999

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    **X** More than 50%: almost 100%. Daily salary of members ranges between 11 and 15 Córdobas (US$0.93 and US$1.27)

11. **Place of residence for the majority of members:**
    **X** rural area: around 100%

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** department: municipalities of Tuma La Dalia, Jinotega, San Ramón and Matagalpa

13. **Type of basic health care services covered by the scheme:**
    **X** preventive care and health promotion
    **X** out-patient care
    **X** midwife services/ reproductive health care

- **X** medicines
- **X** others: vaccinations, dental and paediatric treatments, and health educational programme

**14. Method of financing the health insurance:**

- **X** members' contributions
- **X** voluntary contributions by non-members and other organizations: employer (10 Córdoba =50%)
- **X** Non-state subsidies from development agencies, donors etc. Fondo de Cooperación al Desarrollo (FOC)
- **X** others: transfers from other development activities by ATC

**15. Members' participation in the management of the scheme:**

- **X** administration by the organization responsible for the administration of the MHIS without members' participation other than choice of health services covered.

**16. External technical assistance:**

- **X** receives regular external technical assistance: since September 1999

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

See case study

**-Any bibliographical and written references:**

A case study was carried out jointly by the STEP (Strategies and Tools against social Exclusion and Poverty) Programme, of the ILO Social Security Department, and PAHO (Pan American Health Organization), 1999. For a copy of the case study, please contact Ms. Victoria Giroud-Castiella. Tel: +41-22-799 6072. Fax: +41-22-799 6644. Email: giroud@ilo.org

**-Names of persons and/or organizations that can provide additional information about the scheme:**

For more information, please check http://oitopsmexico99.org.pe

# Peru

I. Seguro del Agricultor – Municipalidad Sama Las Yaras

II. Seguro del Agricultor – CLAS de la Municipalidad de Ite

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## I. Seguro del Agricultor – Municipalidad Sama Las Yaras

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):**
   1995-1997: CLAS - Puesto de Salud Sama – Las Yaras
   1998: Municipalidad Distrital Sama – Las Yaras y MINSA.

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   **Address (state country):** CLAS – Puesto de Salud Sama – Las Yaras: Av. Los Héroes s/n, distrito de Sama - Las Yaras, provincia y departamento de Tacna, Perú
   Municipalidad distrital de Sama – Las Yaras: Av. Las Palmeras 101, distrito de Sama, provincia y departamento de Tacna, Perú
   **Telephone:** +51-44-684 017
   **Email:** neira_r@lared.net.pe
   **Fax:** +51-54-715376

3. **Contact person:** Morayma Salazar Calero, Doctor

4. **Type of organization responsible for the HMIS:**
   **X** non-profit health care provider: CLAS Puesto de Salud Las Yaras

5. **Year (and month) when the scheme was (formally) set up:** December 1994

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** March 1995

7. **Total number of male/female members of the scheme:** 33 women and 50 men in 1998

8. **Total number of members in the organization that has set up the scheme:** Not applicable

9. **Total number of current male/ female beneficiaries of the scheme:** 114 female and 92 male in 1998

10. **Proportion of beneficiaries a) excluded from other social security systems or b) with income below the poverty line:**
    **X** more than 50%

11. **Place of residence for the majority of members:**
    **X** rural area: about 43%
    **X** urban area: about 57%

**12. Geographical area covered by the health micro-insurance scheme:**
**X** province/ region: distrito de Sama, provincia y departamento de Tacna

**13. Type of basic health care services covered by the scheme:**
**X** out-patient care
**X** midwife services/ reproductive health care
**X** medicines
**X** medical evacuations: Transporting patients by ambulance to Hospital Hipolito Unanue
**X** other: laboratory tests

**14. Method of financing the health insurance:**
**X** members' contributions
**X** state contribution: including Municipalidad Distrital de Sama Las Yaras

**15. Members' participation in the management of the scheme:**
**X** administration by the organization responsible for the administration of the MHIS without members' participation other than choice of health services covered.

**16. Technical assistance:**
Does not receive external technical assistance

**17. Other (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
See case study

**-Any bibliographical and written references:**
A case study was carried out jointly by the STEP (Strategies and Tools against social Exclusion and Poverty) Programme, of the ILO Social Security Department, and PAHO (Pan American Health Organization), 1999. For a copy of the case study, please contact Ms. Victoria Giroud-Castiella. Tel: +41-22-799 6072. Fax: +41-22-799 6644. Email: giroud@ilo.org

**-Names of persons and/or organizations that can provide additional information about the scheme:**
Manager of the network.

Municipalidad Distrital de Sama las Yaras

For more information, please check http://oitopsmexico99.org.pe

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# II. Seguro del Agricultor – CLAS de la Municipalidad de Ite

**1. Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** CLAS de la Municipalidad Distrital Ite

**2. Address of the HMIS Head Office (or contact address of the responsible organization):**
**Address (state country):** CLAS-Puesto de salud Municipalidad Ite - Plaza principal
**Telephone:** +51-54 – 740211 (community)

**Fax:** +51-54 – 715376

3. **Contact person:** Carmen Arenas Neyra, Chief doctor

4. **Type of organization responsible for the HMIS:**
   **X** non-profit health care provider: Clas Puesto de Salud Ite

5. **Year (and month) when the scheme was (formally) set up:** January 1997

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** January 1997

7. **Total number of male/female members of the scheme:** Information not available

8. **Total number of members in the organization that has set up the scheme:** Information not available

9. **Total number of current male/ female beneficiaries of the scheme:**
   81 families and 250 individuals in November 1998

10. **Proportion of beneficiaries a) excluded from other social security systems or b) with income below the poverty line:**
    **X** more than 50%

11. **Place of residence for the majority of members:**
    **X** rural area

12. **Geographical area covered by the health micro-insurance scheme:**
    **X** municipal

13. **Type of basic health care services covered by the scheme:**
    **X** preventive care and health promotion
    **X** out-patient care
    **X** midwife services/ reproductive health care
    **X** medicines
    **X** medical evacuations: Transporting patients by ambulance
    **X** other: referral services; nursing programme includes respiratory diseases, gastritis

14. **Method of financing the health insurance:**
    **X** members' contributions
    **X** state contribution: including Municipalidad Distrital de ITE

15. **Members' participation in the management of the scheme:**
    **X** Administration by the organization responsible for the administration of the HMIS with members' participation other than choice of health services covered.

16. **Technical assistance:**
    **X** does not receive external technical assistance

**17. Other (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

The scheme was suspended in November 1998 by the municipal council under Agreements 97, 98.

**-Any bibliographical and written references:**

Strategies and Tools against social Exclusion and Poverty (STEP) Programme, Social Security Department of ILO and Pan American Health Organization (PAHO) joint research.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

Dr. Neyra Zegarra, subregional health of Tacna. Email: neira_r@lared.net.pe, Fax: +51-54-715376

Sra. Alicia Joaquín Gallegos, nurse, Puesto de salud de ITE

# Uruguay

I. Policlínica Unica José Pedro Varela – Complejo de Cooperativas de Vivienda José Pedro Varela

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## I. Policlínica Unica José Pedro Varela – Complejo de Cooperativas de Vivienda José Pedro Varela

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Cooperativas de Vivienda por Ayuda Mutua del Complejo José Pedro Varela

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   **Address:** Avda. Bolivia 2551, Block K. (Sede central ubicada en Zona 3)
   **Telephone:** +598.2.522 05 44 (sede central y Zona 3)
   +598.2.525 15 11 (Zona 1)
   +598.2.522 49 73 (Zona 6)

3. **Contact person:**
   Eduardo Angelini y Hederson Cardozo, members of the Comisiòn Administradora del Complejo, +598.2.525 15 06 and +598.2.525 90 49

4. **Type of organization responsible for the HMIS:**
   **X** co-operative-type organization

5. **Year (and month) when the scheme was (formally) set up:** Policlínicas de obra (Labour Polyclinic) were set up in 1980

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** 1983-84

7. **Total number of male/female members of the scheme:** 1,717 persons

8. **Total number of members in the organization that has set up the scheme:** 1,638 persons

9. **Total number of current male/ female beneficiaries of the scheme:** 3,349 female and 3,091 male

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    **X** If less than 25%, number of beneficiaries excluded or below the poverty line: information on numbers not available

11. **Place of residence for the majority of members:**

**X** urban area: 100%

**12. Geographical area covered by the health micro-insurance scheme:**
**X** municipal: neighbourhoods of La Cruz de Carrasco and Parque Rivera, Montevideo

**13. Type of basic health care services covered by the scheme:**
**X** out-patient care
**X** medicines: including medicines for special treatment
**X** vaccinations
**X** others: nursing care

**14. Method of financing the health insurance:**
**X** members' contributions

**15. Members' participation in the management of the scheme:**
**X** democratic administration of the scheme by members (general assembly)

**16. External technical assistance:**
**X** does not receive external technical assistance

**17. Others (if applicable):**
**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**
See case study

**-Any bibliographical and written references:**
A case study was carried out jointly by the STEP (Strategies and Tools against social Exclusion and Poverty) Programme, of the ILO Social Security Department, and PAHO (Pan American Health Organization), 1999. For a copy of the case study, please contact Ms. Victoria Giroud-Castiella. Tel: +41-22-799 6072. Fax: +41-22-799 6644. Email: giroud@ilo.org

**-Names of persons and/or organizations that can provide additional information about the scheme:**

**Equipo de Representación de los Trabajadores en el BPS (ERT): Ernesto Murro y Ec. Gabriel Lagomarsino, Address: Fernandez Crespo 1621, 5° piso, Montevideo, CP 11200, Telephone: +598.2.401 02 42/401 03 55, email: emurro@bps.gub.uy, fax: +598.2. 408 73 62**

For more information, please check http://oitopsmexico99.org.pe

# Venezuela

I. Sistema Autogestionario de Servicios de Salud – Cooperativa Los Naranjos

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## I. Sistema Autogestionario de Servicios de Salud – Cooperativa Los Naranjos

1. **Name of the organization responsible for the HMIS or its owner (if the ownership is legally defined):** Cooperativa de Servicios Múltiples los Naranjos. Registered as SUNACOOP, under the No. ACSM

2. **Address of the HMIS Head Office (or contact address of the responsible organization):**
   ***Address:*** Urbanización los Naranjos, Centro Cívico, Edif Cooperativa los Naranjos, GUARENAS, Estado de Miranda, VENEZUELA
   ***Telephone:*** +58-36-235997/ 232419

3. **Contact person:**
   José Contreras, President

4. **Type of organization responsible for the HMIS:**
   **X** co-operative-type organization

5. **Year (and month) when the scheme was (formally) set up:** January 1997

6. **Year (and month) when the scheme began to deliver the first benefits to beneficiaries:** Information not available

7. **Total number of male/female members of the scheme:** Information not available

8. **Total number of members in the organization that has set up the scheme:** Information not available

9. **Total number of current male/ female beneficiaries of the scheme:** 2,000 persons

10. **Proportion of beneficiaries excluded from other social security systems or with income below the poverty line:**
    **X** More than 50%: (95%)

11. **Place of residence for the majority of members:**
    **X** rural area
    **X** urban surroundings

12. **Geographical area covered by the health micro-insurance scheme:**

X department: Guarenas City, capital of Municipio Plaza, Miranda

**13. Type of basic health care services covered by the scheme:**

X preventive care and health promotion

X out-patient care

X others: odontology, paediatric, gyneacology and obstetrics, alternative medicine, acupuncture, massage theraphy, homeotheraphy

**14. Method of financing the health insurance:**

X members' contributions: (Bs. 4,000 monthly)

**15. Members' participation in the management of the scheme:**

X democratic administration of the scheme by members (general assembly)

**16. External technical assistance:** Information not available

**17. Others (if applicable):**

**-General assessment of the scheme in terms of how it is functioning, its viability, its weaknesses etc.:**

The health scheme was started in 1997 and recently underwent reorganization. It is viable for as long as it receives institutional support. The contributions it receives from its members and other individuals are not sufficient to sustain the scheme due to the difficult economic conditions in Venezuela. Members and some medical personnel maintain their interests in the health micro-insurance.

**-Any bibliographical and written references:**

PINZON R, Julio Alberto: Plan de restructuración del servicio solidario de salud de la cooperativa los Naranjos, COLACOT, Guarenas Venezuela 1998.

Strategies and Tools against social Exclusion and Poverty (STEP) Programme, Social Security Department of ILO and Pan American Health Organization (PAHO) joint research.

**-Names of persons and/or organizations that can provide additional information about the scheme:**

Alberto Viana: Bloque 33 P2 Apto 02-01 Urbanización Vicente Emilio Soto.

Guarenas, Estado de Miranda, Venezuela.

Tel: +58-36-211 895

Mobile phone: 014 266 303