L'Union Technique de la Mutualité Malienne

Mali

CGAP Working Group on Microinsurance
Good and Bad Practices
Case Study No. 23

Klaus Fischer, Issa Sissouma and Ibrahima Hathie - August 2006

Good and Bad Practices in Microinsurance

This paper was commissioned by the "Good and Bad Practices in Microinsurance" project. Managed by the ILO's Social Finance Programme for the CGAP Working Group on Microinsurance, this project is jointly funded by SIDA, DFID, GTZ and the ILO. The major outputs of this project are:

1. A **series of case studies** to identify good and bad practices in microinsurance
2. A **synthesis document** of good and bad practices in microinsurance for practitioners based on an analysis of the case studies. The major lessons from the case studies will also be published in a series of **two-page briefing notes** for easy access by practitioners.
3. **Donor guidelines** for funding microinsurance.

The CGAP Working Group on Microinsurance

The CGAP Microinsurance Working Group includes donors, insurers and other interested parties. The Working Group coordinates donor activities as they pertain to the development and proliferation of insurance services to low-income households in developing countries. The main activities of the working group include:

1. Developing donor guidelines for supporting microinsurance
2. Document case studies of insurance products and delivery models
3. Commission research on key issues such as the regulatory environment for microinsurance
4. Supporting innovations that will expand the availability of appropriate microinsurance products
5. Publishing a quarterly newsletter on microinsurance
6. Managing the content of the Microinsurance Focus website: www.microfinancegateway.org/section/resourcecenters/microinsurance

Table of Contents

Acknowledgements

The authors would like to thank, first of all, the Director General of the *Union Technique de la Mutualité Malienne* (UTM), Dr. Oumar Ouattara for the ready and cordial support received throughout the process of preparing this case study, starting from the first contacts through the unrelenting assistance in accomplishing the field and writing work, and providing unconditional access to all contacts necessary to collect the information, and for allowing one of the key staff of the institution, Mr. Issa Sissouma, to spend many hours to collaborate in the work and co-author the case study. We also would like to thank the enthusiastic support received from all the staff at the Head Office of the UTM and the Regional Office of Ségou. Finally, very special thanks are due to members of the Board of Directors of the mutual health organizations (MHO) of Cinzana and Kulikoro who spent several hours with the authors and patiently respond to the long litany of questions, and volunteered even more information. We also thank members and directors of the MHO of Post Office and of Ségou for their patience in going through the long interviews.

This report is dedicated to the extraordinary work that the entire movement, from its humble members through the highly motivated leaders, is accomplishing in the difficult task of creating the organizational basis of an institution that is improving quality of life of tens of thousands of Malians, and will hopefully in the not too far future, do the same for hundreds of thousands. They may not know it, but they may be leading the way for millions more to follow in the rest of the world.

Acronyms

AISAM	Association Internationale des Sociétés d'Assurance Mutuelle
AIM	Alliance Internationale de la Mutualité
BI	Bamako Initiative
CF	Coopération Française
CFA	la communauté financière d'Afrique
CFAF	Franc de la communauté financière d'Afrique
CIMA	Inter-African Conference on Insurance Markets
CRCA	Commission Régionale de Contrôle d'Assurance
DPS	Direction Nationale de la Protection Sociale et de l'Économie Solidaire
FSL	Friendly Societies Law
HI	Health insurance
ICMIF	International Cooperative and Mutual Insurance Federation
ILO	International Labour Organization
INPS	Institut National de Prévision Social
MF	Mutualité Française
PHR	Partnership for Health Reform
MHO	Mutual Health Organization
SCAC	Service de Coopération et d'Action Culturelle de l'Ambassade de France
STEP	Strategies and Tools against social Exclusion and Poverty
UMSGF	Union des mutuelles de santé de Guinée Forestière
UTM	Union Technique de la Mutualité Malienne
VMHI	Voluntary Mutual Health Insurance

Executive Summary

This case study is about an institution that is owned, controlled and used by very humble people (street vendors, subsistence farmers, unemployed women, semi-nomad shepherds, among others), living in one of the poorest countries in Africa, Mali. It is a case study about mutual health organizations[1] (MHO) that have started to spring into existence in urban and rural West Africa (mostly French speaking) and provide health insurance to hundreds of thousands of people, up from a few tens of thousands just five years ago. But, while its growth and impact on members is impressive, the mutual movement is struggling to survive and consolidate itself, just like the people it serves. In this movement, the existence of an apex organization capable of providing services needed by individual MHOs is crucial. But the means to support this apex are hardly available. Small variations in economic conditions (e.g., a drought, a flood, locusts) can cause many members to discontinue paying their premiums. This forces them to re-initiate, many months later, the expensive procedure of registration or leads them to abandon coverage altogether.

As of the end of 2005, there are 32 MHOs, with about 40,000 beneficiaries, covering all services offered in public health institutions for which patients must make a co-payment. The insurance typically covers between 60%-75% of this co-payment and members pay a premium that ranges between US$2.20 and US$11.00 per year for this coverage. These MHOs are affiliated to an apex organization, the Union Technique de la Mutualité (UTM), which plays a central role in their development and has been the force behind the growth of the movement since its inception barely five years ago.

Of the countries that have incipient movements of MHOs, only two (Mali and Senegal) are approaching the critical mass of membership that *may* make them sustainable by generating sufficient financial resources to finance the support structures – apex organizations – needed to operate viably and to provide services to individual MHOs.[2] As they stand, they attempt to address the two aspects of the Bamako Initiative (BI) that are the most difficult to put in place: i) creating mechanisms that will finance patient co-payments; and ii) allowing users of the health system to become not just nominal, but effective partners in the decision process of the management of the local health system.

[1] In our understanding, there is no standard English translation to the French word *mutuelle* which makes reference to small user-owned associations that perform mutualization of risk—in our case health risk—that practically always create apex organizations, which perform a key role in the operations of the first-tier organizations. These institutions are not quite comparable to the large mutual insurance companies common in the Anglo-Saxon world, and follow the model of the French *mutuelles* or the German "Krankenkasssen". For the purpose of this report, the expression Mutual Health Organizations will be used in order to be consistent with some published works (although, technically a more appropriate name would be Health Insurance Mutual Association, where the words *mutual association* translates the French expression *mutuelle*, and *health insurance* translates *santé*). Hence, in this report Mutual Health Organizations (MHO) translates the expression *mutuelle de santé (MS)*. Gautier *et al* in the case study (No. 17) of the Union des Mutuelles de Santé de Guinée Forestière (UMSGF) also use this term.

[2] In Africa, movements of MHO have started in Bénin, Burkina Faso, Cameroon, Côte d'Ivoire, Guinea, Mali, Mauritania, Niger, Sénégal, Tchad and Togo, summing to a total of 325 MHOs in 2003 (Source: STEP *Inventaire des mutuelles de santé en Afrique*).

There is a set of features in this case study that must be noted, specifically with respect to the institution under study:

1. MHOs are *market-led* institutions that have, at least in the middle to long run, the potential to become subsidy free, and perhaps extend coverage to a large portion of a country's population, starting at the upper level with state employees and factory workers and reaching down to micro-farmers, craftspeople, women's groups and other special interest groups.[3] In some of Mali's health districts, this movement already finances nearly 50% of health spending.
2. We use the expression "market led" to express the fact that these MHOs are institutions that must attract customers from the target population by offering competitive health insurance packages, while having to face open market prices for the provision of health services. While among the poor, they are the only providers of the health insurance services, for upscale segments of the market, they are in competition with other actors, including public and investor-owned health insurance schemes. Once economies of scale have been reached, no direct subsidy will support the operations of the individual MHOs and they should generate sufficient operational surpluses to finance their affiliation to the apex organization (the UTM), which in turn, provides a range of services.[4] The independence from donor funding would make the system potentially sustainable and could provide a permanent solution for accessing health services.
3. Thus, the single most important challenge facing the movement is to reach sustainability. However, there should be realism about this goal. Even movements with an indisputable historical success, such as the Bismarckian mutual "Kranken Kassen" in Germany or the French "Mutualité", today both providing health insurance to the majority of their respective populations, were dependent on state subsidies for decades before reaching sustainability. It would indeed be unreasonable to expect that *any* movement that provides this essential social service to large portions of the poorer population will reach sustainability in such a short time.
4. These individual MHOs have a natural proclivity and respond positively to initiatives to create technical apex structures that are governed in a bottom-up fashion and thus giving users a say in all decisions. The apex organizations are designed to support the operations of individual MHOs through a variety of services such as: reinsurance, negotiation and wholesale contracting of health service provisions, administration and accounting services, and the settlement of payments with service providers.
5. The proclivity to create inter-MHO alliances can at once solve many difficult problems that microinsurance institutions typically face. The benefits include being able to: remain small and close to the community being served, limit adverse selection through group insurance schemes and exploit the value of "soft" information available in the community. At the same time, these alliances allow for exploitation of economies of scale by consolidating demand for health services within the network, limit covariant risk by

[3] A feasibility study performed under the sponsorship of the *Cooperation Française*, in collaboration with the UTM and the *Mutualité Française*, suggests that the movement should become self sufficient with 50,000 paying members.

[4] Currently, the subsidy comes in form of operations support to the apex organization, the UTM. To the extent that the UTM provides services to individual member MHOs, there is an implicit subsidy to individual MHOs.

pooling risk throughout the network (through network reinsurance schemes or pooling of reserves as done by the UTM), and quality control by standardizing management, accounting and risk management practices.

6. Once a network has a critical mass of technically efficient MHOs and the network structures provide essential services to them, the only further input required to make the system sustainable is an adequate regulatory and supervisory framework. This framework must provide legal backing to the operations of the individual MHOs and the network structures they create, with *the later being as essential for their survival as the prudent management of the individual mutual associations and their links to the communities they serve*. While sustainability has not been reached in the West African countries – and certainly not in Mali – there are many networks of mutual organizations in the world in the *Aliance Internationale de la Mutualité* (AIM), the International Cooperative and Mutual Insurance Federation (ICMIF) and AISAM (*Association Internationale des Sociétés d'Assirance Mutuelle*) that are not only sustainable, but also have considerable financial means.
7. Strictly speaking, mutuality, particularly in the form of mutual financial intermediaries, is an organizational form of European origin. However, the experiences of the last decade in several West African countries, as well as spot experiences around the world, and the sheer enormity of the global cooperative and mutual savings and loans movements, suggests that the cultural tradition is not a barrier to adoption.[5] The fact that mutual organizations already existed in Mali during colonial times makes them institutions with which many Malians are familiar and are willing to trust, *despite* their French origin. This is true also for other West African countries with a French colonial history and for countries from around the world where the British introduced friendly societies legislation (Australia, India, New Zealand, and South Africa among others). An absence of that tradition does not impede the adoption of these institutions; it only suggests that the process of introduction and build-up may be slower and more laborious.

With respect to the insurance product they provide:

1. Due to the basic government health service funding (which includes free-of-charge services and services where the user fees only cover a fraction of the cost of producing the service), insurance should be viewed as a *complementary health insurance*. It is an open question whether these institutions would be able to provide satisfactory insurance in a system that charges the full cost of services to users.

2. The Union Technique de la Mutualité (UTM) is experimenting with two product lines (with considerable success). Firstly, it is experimenting with health insurance adapted to the needs of specific communities. A number of MHOs offer very specific plans that have

[5] Further, mutual-like organizations existed long ago in societies other than Europe. China, India, Indonesia are some examples of societies where mutual organizations existed and played similar roles to those in Europe. Thus, it is incorrect to say that mutual organizations are a "European phenomenon", although the particular organizational form taken by MHOs are copied from Europe. In the case of France, on which the Mali system is inspired, mutuality took care of health insurance of practically the entire population that did not have access to a private insurance company up to the Second World War. Only after the war did France introduce a public system financed by the state. Since, MHOs provide complementary health insurance to over 60% of the population. The percentage of the population covered by some mutual insurance members of the AIM ranges from less than 5% in Italy and Greece, to over 90% in Belgium and Switzerland.

been selected by the communities involved. The premium for these plans is as low as US$2.20 per year per beneficiary. Simultaneously, the UTM has launched a highly standardized trademark product of health insurance, which attracts large segments of the urban population. This product is so competitive that many formal workers covered by the statutory state-sponsored health insurance plan choose to affiliate themselves to an MHO to have access to the plan. Furthermore, this standard plan dramatically simplifies management at the MHO level and allows for the exploitation of economies of scale. The premium for this standard plan, which includes all pathologies (even ophthalmology and dentistry), is US$0.85 per person per month.

1. The Context

1.1 Macroeconomic Data

By income per capita, Mali is one of the poorest countries in the world. Yet, it has been the cradle of some of the most important civilizations that existed throughout African history starting as far back as the II[nd] century A.D. (the Ghana Empire, or the "Empire of Gold").[6] Today, its competitive advantages are few. It is landlocked, with most of its territory sitting on the Sahel, with the Sahara to the north and a small tip of the richer subtropical plains, with 65% of its land area desert or semi-desert. In the north, there is no rain or just a few weeks of rain and there are only 3-4 months of rain in the south. The main export items are cotton and cotton industrial products benefiting mostly the small southern tip, followed by production of gold – also in the south – from the mines of Sadiola, Molrila and Kalana. Throughout the rest of the country, the economy depends on farming (mill, sorghum and peanuts) and cattle and goat rearing (in the Sahel region).

Table 1.1 Macroeconomic Data (mostly 2003)

GDP (US$ Billions) (PPP)	10.53
Population (millions)	11,111,000[1]
Population density per km^2	8.9[1]
Percentage urban / rural population	30% urban[1]
GDP/Capita (US$)	725
GDP Growth Rate	1.9[1]
Inflation	-1.3%[1]
Exchange Rate (current, X Currency per US$1)[7]	518 F.CFAF/US$
PPP GDP per Capita	900[1]
Infant Mortality (per 1000 live births)	117.9[1]
Under Five Mortality (per thousand)	220
Maternal Mortality (per 100,000 live births)	1200
Access to safe water (% of population)	48.0
Health Expenditure as % of GDP (public/private/total)	2.3/2.2/4.5
Health Expenditure per capita (US$)	12.0
Doctors per thousand people	0.0
Hospital beds per thousand people (urban/rural)	0.2
Literacy rate	46.4% (M=53.5; F=39.6)

[1] *Le Mali en chifres. Direction nationale de la statistique et de l'information* (DNSI). Nov. 2004.

Mali presents a highly unequal distribution of income. The poorest 10% of the population has only 1.8% of national income while the richest 10% has 40.4% of the national income (1994 est.). Economic activity is largely confined to the riverine area irrigated by the Niger and depends on agricultural products. The GDP composition is 45% agriculture, 17% industry and 38% services (2001 est.). About 10% of the population is nomadic and some 80% of the labour force is engaged in farming and fishing. Industrial activity is concentrated on

[6] Followed by the Mali Empire (XIIIth-XVth centuries) and Songha Empire (XVth-XVIth centuries), the latter with Timbuktu as capital.

[7] This exchange rate will be used in all calculations of current figures in this paper. The currency is the Franc CFA (CFAF), the common currency of the West African Monetary Union.

processing farm commodities. Mali is heavily dependent on foreign aid and vulnerable to fluctuations in world prices of cotton, its main export, along with gold. Mali's adherence to economic reform and the 50% devaluation of the African franc (the CFAF) in January 1994 kept economic growth at a sturdy 5% on average in the period 1996-2002.

Seventy percent of the population lives in rural environments and 64% of the population finds itself below the poverty line. The combination of a significant rural population, high poverty, highly unequal distribution of income, nomadic populations and low literacy rate poses a particular challenge to the provision of health services. Mali ranks 167th in the 2002 UNDP Human Development Index.

1.2 Legislation and Regulation of Health Insurance

MHOs in Mali are not regulated by an insurance regulation framework, but by the specialized mutual association law of 1996 (known as the "*Régissant la mutualité en République du Mali*"). This law regulates a special statutory institution defined as a "*mutuelle*"(the MHO) with the following functions (Art. 2):[8]

- prevent social risks related to people and redress their consequences;
- protect the welfare of old or handicapped people, families and children;
- protect the cultural, moral, intellectual and physical development of their members and improve their living conditions.

This law, like the system it is designed to support, is based on the French experience and the French *Loi de la Mutualité*. A mutuality law is essentially legislation that regulates a specialized association designed specifically for the provision of social security services, including insurance services through mutual institutions. In Mali, like in several other countries, this legal framework is separate and parallel to the one regulating investor-owned insurance institutions.

In the case of Mali and most French-speaking countries of West Africa, non-mutual insurance providers are regulated by the investor-owned insurance companies' framework known as the common Inter-African Conference on Insurance Markets (CIMA) code and its execution body, the Commission Régionale de Contrôle d'Assurance (CRCA). Since it is of no consequence for MHOs, we will not enter into details about the CIMA code and its application. Some information about CIMA is provided in Box 1.1.

[8] Article 2 of the law defines the mutuelle as "*des groupements à but non lucratif qui, essentiellement au moyen des cotisations de leurs membres se proposent de mener dans l'intérêt de ceux ci ou de leurs familles une action de prévoyance, de solidarité et d'entraide*."

Box 1.1 CIMA

In the French sub-Saharan region, supervision of the insurance industry falls under a regional insurance supervision council, the CRCA. Since the founding of the CRCA in July 1992 to implement the CIMA Treaty of Yahoundé, Cameroon, regional insurance regulations (the CIMA Code) have been harmonized, and supervision has been considerably strengthened. The code became effective in 1995. This body has applied uniform regulatory and supervisory rules and practices that have enabled the establishment and operation of companies in the region, where local and foreign (mainly French) companies operate side by side. Members of CIMA are Benin, Burkina, Cameroun, Central African Republic, Congo, Ivory Coast, Gabon, Guinea Bissau, Equatorial Guinea, Mali, Niger, Sénégal, Chad and Togo. CIMA is a highly regarded insurance supervision arrangement with the following characteristics:

* Operational independence
* Adequate powers, legal protection and resources
* Transparent process and accountability
* Adequate staff with high professional standards

However, from the point of view of microinsurance, the CIMA code may be an obstacle since it limits individual countries the flexibility to accommodate microinsurance initiatives. On the plus side, if the region ever decides to create a regulatory framework for encouraging microinsurance development, it will probably apply to the entire region. Currently, the CIMA code is of no concern to MHOs since they are regulated under a different legal regime.

The government agency in charge of the MHO movement is the *Direction de la protection sociale et de l'économie sociale* (DPS), a body of the *Ministère du développement social, de la solidarité sociales et des personnes âgées*. The DPS' mission is to:

- Design and implement policies
- Elaborate and propose legal texts that guide the sector (the mutuality laws in this case)
- Insure the application of these laws (including the mutuality law).
- Promote the development of the mutual institutions through training programs or material support
- Supervise MHOs and other mutual organizations.

The DPS is also the agency that provides operating licenses to new MHOs. For the time being, the DPS offers very little supervision of MHOs.[9] The reason stated by the director general of the DPS is that it still has to train its own personnel to ensure they have the capacity to provide the support and supervision required. With respect to the monitoring function, the government has issued a decree in which the procedures for the supervision of mutual institutions are spelled out with considerable detail. These procedures also involve another body of the ministry, known as *L'inspection des affairs socials*, with more specific

[9] In 2004, a supervision guide (*Guide pour le développement e la mutualité au mali à l'intention des agents de la tutèlle*) was prepared by *Service de Coopération et d'Action Culturelle de l'Ambassade de France* (SCAC) and the UTM. This guide presents a very detailed description of procedures that should be used in the process of supervising the MHO as well as the minimum accounting standards that must be respected by them.

supervisory functions. The entire ministry and its different divisions are under the control of this body, which also has the function of inspecting MHOs on demand of the DPS or the minister. The closure of mutual institutions can be decided by *l'inspection.* The DPS mostly performs "off-site" supervision, relying on reports produced by the mutual enterprises. Although it has nine regional bureaus that perform on-site inspection of mutual institutions, the DPS recognizes that for the time being an adequate on-site supervision is not possible due to the lack of human resources. The DPS also justifies its somewhat lax approach because of the short life of the law and the period needed to adapt institutions to the framework. The DPS also relies to some extent on the UTM to monitor the MHOs. However, there is no formal delegation of the supervision functions to the UTM.

The DPS sees itself as a specialized body for the promotion and supervision of mutual insurance, acting as a complement to the CIMA structure. It is deeply involved in a current debate in West African countries. In this debate, certain parties have advanced the idea of harmonizing the regulatory standards for mutual and investor-owned institutions. Some of the propositions reflected a total lack of understanding of the specificities of mutual institutions (See Box 1.2). This is despite the fact that some of the NGOs participating in the debate were officially representing national movements of mutual organizations. However, no leaders of the mutuality movement were actually present at the debates because they were not invited. *In fact, Mali fears the risk of a West African wide harmonization that ignores specificities that could have negative consequences for the movement of mutual organizations in the country, and sees itself as a strong voice in defending the need of an adapted regulatory framework for mutual institutions.* The functionaries of the DPS are of the opinion that the debate about regulation of microinsurance in West Africa ignores the movement of mutual organizations (the *mutuelles de prevoyance* in the largest sense, of which the MHOs are just one form), despite the fact that they are by far the largest microinsurance provider in the region. It insists that if there will be a harmonization at the regional level, this harmonization must recognize mutual organizations as distinct institutions, not as investor-owned insurers, with a legal and regulatory framework that takes this specificity into consideration.

Box 1.2 Mutuality Laws

In the Anglo-Saxon context, these laws are the equivalent of a Friendly/Fraternal Societies Laws (FSL) for insurance providers or a Building Societies/Credit Union Law for credit institutions. Friendly societies have been governed by specialized legislation in the United Kingdom for more than 200 years. Although the first Friendly Society Act was introduced in 1793, in 1773 a Bill was already brought to the House of Commons entitled "An Act for the better support of poor persons in certain circumstances by enabling Parishes to grant them annuities for life, upon purchase, and under certain restrictions".

While the typical FSL is considerably more forgiving on restrictions on capital, reserves, risk taking practices etc., they typically limit strictly the field of activities allowed to the institutions they regulate. Friendly societies (sometimes called a mutual society, benevolent society or fraternal organization) are special statutory institutions that unlike individuals, partnerships or companies have no choice in the matter of the business that they carry on and are limited to the purpose for which they are created and established by the law. These institutions typically present limitations over general purpose companies such as: i) restricted object; ii) dispersal of internal control rights; iii) limited residual risk of members; and iv) limited residual claims.

For example – and this is the case of the UTM system – the regulatory framework does not require a minimum capital, a solvency ratio, minimum reserves or reinsurance. In fact, in contrast with investor-owned insurance companies, by definition a mutual insurer has no capital, although it may accumulate reserves. This is because policyholders (members) pool residual bearing of risk, which is a key feature of mutual insurance enterprises. This pooling of risk acts as a substitute for capital. Thus, members do not make an equity contribution to start the enterprise. Not surprisingly, a considerable number of "standard" practices of insurance regulation and supervision are inapplicable to the institutions studied in this case study, while others not of use in stock-based insurance companies become important in regulating these enterprises. Indeed, the best way to suffocate the MHO movement in Mali, or elsewhere, would be to impose on it a regulatory framework designed for limited liability companies, however "micro-oriented" they may be.

1.3 Industry Performance Information

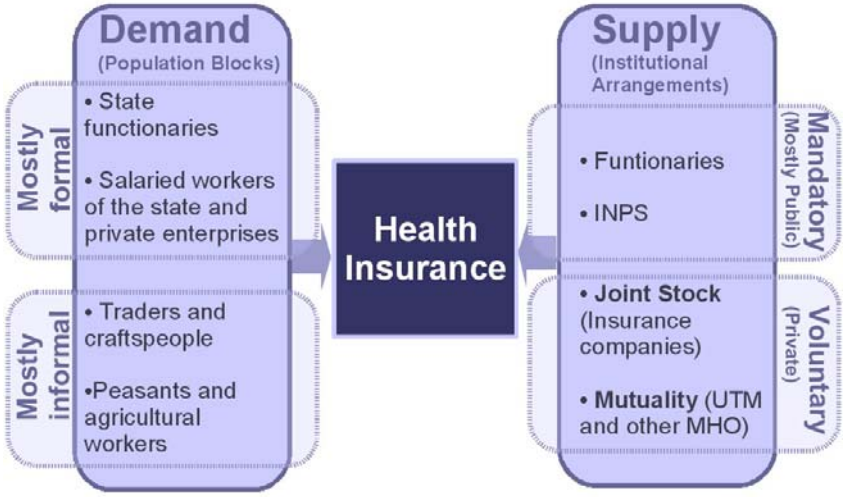
Figure 1.1 summarizes the Malian health insurance system. There are two statutory schemes in place, with a third – based on the principle of mutuality and led by the UTM – that is targeted at the informal economy. One of the two statutory insurance schemes is for functionaries of the state; and the other is for employees in formal sector enterprises. Both these statutory schemes are *mandatory*. Functionaries of the state are covered for 80% of hospitalizations (with a co-payment of 20% required from users). There is no coverage for other (primary) health services. Certain functionaries with a particular status (police and armed forces) have access to dispensaries and infirmaries that cover their health service needs. Employees of formal sector enterprises and non-functionary employees of the state are covered by a double statutory schema:

1. As in the case of the functionaries of the state, a 80% coverage for hospitalizations, which is charged to the enterprise (or the state for its non-functionary employees);

2. For general medicine, a regime known as the *Institut national de la prevoyance sociale* (INPS, National Social Protection Institute) covers employees and members of their family. This is the most comprehensive scheme available in the country (except for MHOs) with the following coverage:
    - medical consultations
    - drugs (according to an established list and availability)
    - analysis and laboratories
    - radiology

The INPS delivers services through an infrastructure of facilities under its control. For services beyond its technical competence, affiliates are referred to hospitals and all bills are covered by the INPS. The INPS is financed by three types of contributions by the employer: a flat 8% of salaries/wages for the "family coverage"; between 1%-4% (mean 2%) for "work accidents"; and a flat 2% for "prevention." The INPS also created a *voluntary* regime designed for non-salaried self-employed individuals (accountants, lawyers, consultants, etc.). This voluntary regime is not operational.

Figure 1.1 The Mali Health Insurance System



The two statutory schemes have an unsatisfactory level of performance. Certain enterprises, being aware of the limitations of the coverage of the INPS, have introduced private health insurance arrangements, including making use of private insurance companies to setup collective regimes.[10]

The commercial insurance sector provides health insurance to a small group of better-off people, either through personal insurance premiums or through a few group insurance schemes provided by enterprises. In some cases, these schemes are in addition to the INPS.

Technicians of the UTM estimate that the formal health insurance system covers less than 20% of the active population. Thus, 80% of the population has no insurance coverage other than the basic package provided by the state through its health service infrastructure and thus subject to legal "out-of-pocket" user fees. In general, this portion of the population could be called the "informal economy". This population constitutes the potential market for the "voluntary" MHO system led by the UTM.

With respect to the system under the administration of the INPS, there are a number of criticisms that have been advanced in documents produced by the Mali government as well as the International Labour Office. The main criticisms are:

1. The INPS is based on its own network of dispensaries, which was conceived as a temporary arrangement until the establishment of an "authentic" system of health insurance. The temporary character is reflected in its primitive coverage and inefficient operations.
2. Most INPS dispensaries are badly equipped, resulting in poor services for the insured and referral to hospitals for services that should have been provided in the dispensaries.
3. The coverage of key services such as pharmacy and specialized services by the INPS is unsuitable. Only "basic services" and maternity are covered by the INPS.

[10] See Letourmy and Diakité (2003) for details on these arrangements.

One other variant, interesting for the purpose of this case study, is the creation of enterprise-MHOs, some of which are older than the UTM. But these have now affiliated to the UTM and provide complementary voluntary health insurance. Two examples of mutuals associated with enterprises are the MHO of La Sotelma and the National Post Bureau. Further, according to estimates by Letourmy and Diakité (2003; 22), there are 22 enterprises that have employees affiliated to an MHO member of the UTM, particularly in the region of Bamako. To facilitate the access of these individuals to the voluntary regime, the UTM has created "professional" MHOs in three major urban centres. It is common for functionaries to affiliate to one of these "professional" MHOs to improve their coverage from the statutory system.

During interviews in the city of Segou with the local "professional" MHOs, members reported that although they contributed to the obligatory INPS plan, they were willing to affiliate to the standard voluntary plan offered by the UTM affiliated MHO – paying twice for health insurance – due to the superior coverage it offered, although premiums at the MHO are lower than those of the INPS. The membership of functionaries and employees of private and public enterprises in UTM-affiliated MHOs is seen as a positive development because it supplies a regular income that supports the much needed economies of scale required both at the level of the individual MHOs and the overall system. It also demonstrates the quality of the coverage offered by the UTM system.

Although it is difficult to believe, the UTM has not seen evidence that this development represents massive adverse selection. The UTM has carefully monitored the use of medical services by these affiliates and it use does not appear to be abnormally high. There is, as in the rest of the system, a dilution of the adverse selection effect through the affiliation of entire families rather than individuals.

There is currently a very intense debate about reform of the obligatory health insurance regime to improve its efficiency and coverage. Among the alternatives under consideration to reform the current statutory health insurance regime is the creation of a movement of MHOs, similar to the one led by the UTM, that would assume the coverage of the population currently covered by the INPS. In effect, the UTM could find itself playing a central role in the development of a reformed obligatory health insurance regime. In this regime, as in Germany's Bismarkian system, employees in the formal sector would be forced to affiliate to an MHO affiliated to the UTM offering something similar to the "standard" plan offered by the UTM (an Obligatory Mutual Health Insurance, OMHI, plan), which will be expanded upon later. However, it is worth noting some important aspects in this development:

1. On the positive side, such a regime would bring the UTM closer to the break-even point and thus sustainability. This is obviously a very desirable development.
2. On the negative side, the UTM could find itself having to manage a very large project that could divert its efforts and focus away from its primary target market.

1.4 State Promotion of Health Insurance

To understand the involvement of the government in the health insurance process, one must make reference to the Bamako Initiative (BI), to which Mali adheres (see Box 1.3). Following the health reforms of the 1980s, the most notable change was the introduction and

expansion of payment systems of user fees. Sub-Saharan Africa was probably the area where they were most widely introduced. The economic problems facing African countries in the 1980s had adverse consequences for the health service provision and these countries experienced difficulty in implementing a policy of primary health care. This situation led to the BI[11]. Two essential features of this initiative are:

- Community involvement in the financing of the health service.
- Participation of the community in decisions taken by the local health service provider.

Box 1.3 The Bamako Initiative

The Bamako Initiative (BI) was launched in 1987 by a group of African Ministers of Health in Bamako, in a conference sponsored by the WHO and UNICEF. The BI was a response to the rapid deterioration of access experienced in health systems during the 1980s. The goal of the initiative is to improve access to basic health care services for the entire population, particularly low-income sectors. The BI identified four specific objectives: i) reinforce management and financing mechanisms at the local level; ii) promote community participation; iii) reinforce the provision, management and use of essential drugs; iv) insure a steady financing for health service units.

In practical terms the initiative may be described through the following example: Donors provide a stock of essential generic drugs to the dispensary management committee (composed of representatives of the population). The drugs must then be sold to users at a profit. This profit, in addition to payments for consultations, serves to buy back the initial stock of drugs, and to improve access to care and quality of service (staff incentives, building repairs, etc). The co-payments that apply are presented below:

Co-payments for a variety of health services

Small risks	*Co-P(%)*	*Large risks*	*Co-P(%)*
Consultation	40	Hospitalization	20
Specialist	40	Surgical interventions	20
Essential Medicaments	30	Maternity	20
Analysis	40		

Definition: "Basic health care services" includes, at a minimum, emergency care, inpatient hospital care, inpatient physician services, outpatient physician services, ancillary services such as x-ray services and laboratory services. Source: The *Maine Insurance Code*.

The initiative had the objective of facilitating access to health services by encouraging financial participation of communities and simultaneously encouraging their involvement in the local management of health services. Mali, in particular, had started implementing the BI as early as 1990. Within this context, there was a strong drive to increase the availability of basic health services through health centres associated with administrative health districts (*aires de santé*).

Five years later, after an evaluation of the experience, authorities observed that there was no increase in the demand of the services. This lack of effective demand was attributed to the

[11] Ridde, Valérie, "Fees-for-Services, Cost Recovery, and Equity in a District of Burkina Faso Operating the Bamako Initiative," *Bulletin of the World Health Organization*, 2003, 81, 532—538.

difficulty for people in facing the payments that were stipulated by the BI. Since, in general, there were no other mechanisms available that implemented other forms of community "financial involvement," the "community cost sharing" translated into patients being charged a user fee. Similarly, the absence of mechanisms that made community participation in decision-making effective meant that the second goal was rarely put into practice.

The government continues to display considerable enthusiasm in implementing the recommendations of the BI and to extend the network of primary health centres required. This can be seen, for example, by the per capita total expenditure on health (at average exchange rate), in Figure 1.2a (Source WHO). Furthermore, it is interesting that the government has been targeting the poorer segments of the population as Figure 1.2b suggests. In addition, this trend has been accompanied by a fall in prepaid plans as percentage of private expenditure on health (Figure 1.2c).

Although there is a general policy of user fees (associated to the concept of the BI), there are a number of exemptions. Further, user fees correspond only to a fraction of the costs of service delivery. Therefore, there is a basic "statutory" health insurance coverage built into the system and provided by the state. Further, by the decree of 31 of June 2002, persons affected with "social chronic illnesses," such as tuberculosis, leprosy and cancer among others, may receive free treatment.[12] Indigents are also covered but must present a document issued by a local authority certifying their condition. Other minor exemptions exist. Thus, any insurance scheme designed to finance the user fees, in effect co-payments, should be viewed as a *complementary health insurance* plan. The collective cost and co-payments for a variety of services presented in Box 1.3 reveals that for smaller risks, co-payments can be quite substantial, even for the most basic of the services: consultation (40%) and analysis (40%).

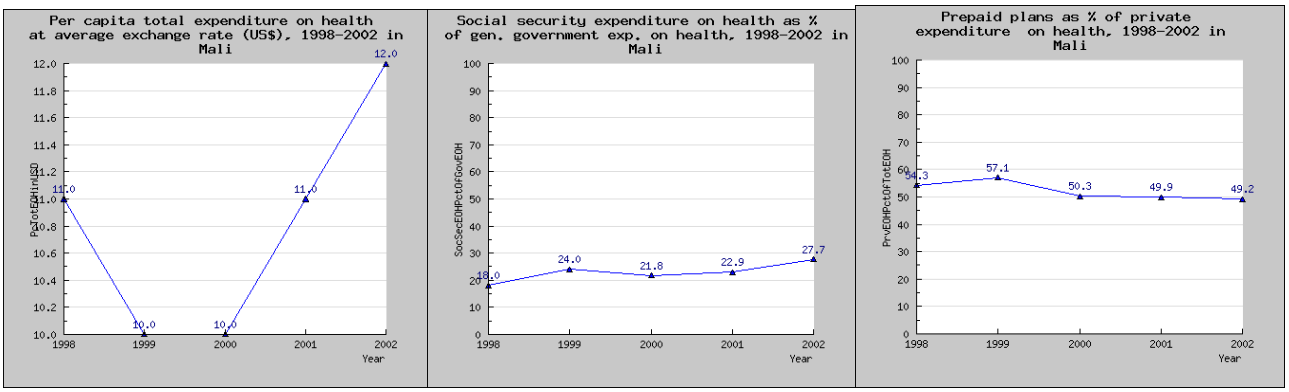
Under these circumstances, the government called upon the *Mutualité Française (MF)* to help in the creation of a system of MHOs.[13] Although at the time, there was a rudimentary system of mutual organizations in Mali, they generally did not offer health insurance and, in most cases, were associated with formal organizations (enterprises and state bodies). The innovation the government was seeking by addressing the MF was in health insurance.

The state displays an active engagement in improving health insurance in the country and played a decisive role in encouraging and facilitating the development of the existing MHO movement. It is also aware of the serious shortcomings of the current arrangements with respect to two aspects: i) the quality of the service provided to those under the mandatory health insurance system; ii) the lack of coverage of vast segments of the population. In consequence, it has engaged in a number of improvements that are both realistic and within its means. There are several sets of activities that result from this strategy:

[12] The list of diseases covered by this arrangement is established by a ministerial ruling.

[13] The *Mutualité Francaise* is a system of 3000 MHO that provides health and social insurance to approximately 60% of the population of France. This system is highly structured into a tight network of first and higher level organizations with complex set of functions. An excellent overview of the system (in French) is provided in the web site: http://www.mutuelleepargneretraite.fr/-Mutualite-Francaise-. This system is regulated by a special legal framework known under the name of the "*Code de la Mutualité*" with a special law ("*Loi de la Mutualité*") the first of which was issued in 1898. Other European countries operate with a similar framework.

Figure 1.2 Expenditure on Health



Source: WHO

- The expansion of the network of health centres strategically located in districts (*aires de santé*) covering the country. The goal of this activity is to improve the physical access of the population to basic health services under the regime of community participation (financial and decisional) implied in the BI.
- The improvement of the legal and regulatory framework that supports the functioning of the movement of MHOs – and thus the UTM – as providers of voluntary (complementary) health insurance to the informal economy. The voluntary regime managed by the UTM was developed under the legal framework of the Law n^{o} 96-022 of February 21, 1996, with complementary decrees 136 and 137 of May 2, 1996. This law allows salaried functionaries to adhere voluntarily to regimes of health insurance other than the INPS. The MHOs affiliated to the UTM are one of the mechanisms opened by this legal framework.
- A strategy of promoting the formation of MHOs, which in coordination with the MF, consisted of the creation of the UTM, with the double function as an apex organization for existing MHOs and as a promotion agency for the development of new ones. Therefore, the UTM, although a non-government apex organization of the MHOs, can be viewed as the centrepiece of the government's policy in providing health insurance coverage to the informal economy.
- A drive to reform the current system of mandatory health insurance – based on the INPS – is to improve efficiency in both insurance coverage and service provision. The goal is to provide health insurance for the families of salaried personnel, functionaries and retired individuals.[14]

1.5 Micro Health Insurance in Mali

While our focus is on the system lead by the UTM, there are two initiatives, both based on the principle of mutuality, to provide health microinsurance in Mali. The first and most important in terms of membership and consolidation is the one lead by the UTM. We present details of this system in Sections 2 to 7.

[14]Other initiatives exist, such as the creation of a Medical Assistance Fund to cover the user fees by state service providers for individuals unable to cover these fees. We will not enter into details about this project.

A second initiative, led by the Partnership for Health Reform (PHR) and financed by USAID, undertook an effort in parallel to the MF/UTM to create MHOs. In contrast to the MF, the PHR did not make any special effort to develop an apex organization, limiting its efforts to the creation of the individual MHOs. This program has ceased and, according to personnel of the UTM, a few of the associations have since applied for affiliation to the UTM, while the rest have had considerable difficulties in maintaining operations or have closed down. In other words, it is unlikely that this initiative will have a long impact, and MHOs created under it will most likely to be forced to affiliate to the UTM to survive.

Table 2.1 Mutual Health Insurance Industry Basics

Issues	Observations
Name of insurance regulatory body	*Direction nationale de la protection sociale et de l'économie solidaire* (DPS). A body of the *Ministère du développement social, de la solidarité sociales et des personnes âgées*
Key responsibilities of the regulatory authority	• Proposing laws • Advise on policies • Supervise implementation of Law • Licensing of MHO (and other mutuals) • Supervision
Minimum capital requirements for insurance license	No minimum capital requirement in line with the tradition of mutuality laws. Minimum number of membership based on feasibility study.
Other key requirements for an insurance license	Feasibility study. Strict restriction on permissible activities (products) apply
On-going capital requirements for a MHO	None. However, reserve accumulations equal to 30 % of operating surplus, and maximum utilization of accumulated reserves of 70% after which the MHO must find other ways to cover losses.
Minimum capital requirement for reinsurer	N.A.
Number of regulated MHO	Approx. 30.
Number of re-insurers (if any)	None
Value of annual premiums of reinsurers	N.A.
Other unregulated organizations, if existing, that offer health insurance	None to our knowledge. NGOs have tended to collaborate with the UTM promoting the formation of new MHO rather than creating their own insurance scheme.
Certification requirements for agents	N.A.

2. The Institution

2.1 History of the UTM

The creation of the UTM is the result of the call of the Mali government made to the *Mutualité Française (MF)* and the *Service de Coopération et d'Action Culturelle de l'Ambassade de France* (SCAC) to help develop a network of MHOs targeting the informal economy. This followed the realization that increasing the availability of basic health services did not result in a significant increase in the demand for these services because the poor population faced difficulties in paying the user fees required under the BI.

By 1995, there were about 15 mutual organizations. Most of these organizations concentrated efforts on pension plans. In 1996, the governments of Mali and France signed an agreement for the execution of a project to support the development of mutuality in Mali. This project gave particular emphasis to the health insurance component. In the same year, a new mutuality law was passed, which provided legal support for the movement of MHOs led by the UTM.

The UTM was created in 1998 with a double function: i) to be the agency that implements the project, and ii) to become an apex structure providing support to new and existing MHOs. These are, to some extent, incompatible functions. As implementing agency, the UTM is a private institution with public policy functions that must take into consideration political objectives and common interests. As an apex organization, it is a private institution that must protect the interest of the affiliated members. This double function also confuses the financing and the measures of sustainability of the model. As an implementing agency, it is natural that it will use public and international aid funding to expand the model according to government objectives. At the same time, this means that as an apex it uses financial resources that are far beyond the means of the member MHOs.[15] However, despite this strong top-down approach, the UTM was not created as a government agency, but as an apex organization of the existing mutual institutions. In its original design, the UTM could affiliate only mutual organizations offering health insurance. Since only five of the then existing mutual organizations offered this service, only they became members of the UTM.

In 2000, mutual organizations that do not offer health insurance also became members of the UTM. However the principal goal of the UTM and its main field of activity remains health insurance. In particular, these new members were encouraged to develop health insurance, for which the UTM offers its technical advice. The challenge of extending health insurance to mutual organizations that did not offer it contributed to the decision to develop the "standard Voluntary Mutual Health Insurance" (or simply the VMHI, or in French *l'assurance mutuelle volontaire* or *AMV,* a trade mark). More will be said about this VMHI plan later on. This

[15] This is the reason why the Mali experience is sometimes described as the "agency approach", giving the impression that the UTM is a government controlled agency that performs the promotion of the MHO movement. This is a misleading characterization. The UTM is not a government agency but an apex organization of the first-level MHO. What is peculiar of the UTM is that this apex was created with substantial decision powers over its members and a sizable scope of functions while its basis is still underdeveloped. However, those powers are not much different from other "strategic" apex organizations in other mutual movements in the insurance and savings and loans fields.

particular plan is at the heart of one of the critiques by outside observers to what we could call the "UTM-model."

At the beginning, the government displayed a clear preference for the direct control of the UTM by giving it the status of a government agency. However, after some give and take, the notion of UTM as an apex organization of incipient MHOs prevailed, giving the movement a similar structure as that found in Belgium and France among others. In this system, from the beginning, the MF simultaneously undertook the work of organizing MHOs in rural and urban communities around Bamako and the work to develop the apex organization (the UTM). With the growth in the number and membership of MHOs, the apex organization was reinforced and its functions expanded to provide a full range of services to the member MHOs.[16]

Today, the UTM has reached a reasonable degree of consolidation and appears to be on a steady expansion path. While sustainability has not been reached in Mali – or in the other West African countries – there is a considerable degree of optimism that it is a matter of time before some of the networks in the region will reach this much-treasured goal. There are indeed many networks of mutual organizations in the world in the *Aliance Internationale de la Mutualité* (AIM), of which the UTM is a member, the International Cooperative and Mutual Insurance Federation (ICMIF) and AISAM (*Association Internationale des Sociétés d'Assirance Mutuelle*) that are not only sustainable but mobilize considerable financial resources. (See Box 2.1)

Box 2.1 International Mutuality Organizations

Three international organizations represent mutuality on a world level: the AISAM, the AIM and the ICMIF. The AISAM (*Association Internationale des Sociétés d'Assirance Mutuelle*) mostly affliates life and non-life mutual insurance companies. The AIM (*Alliance Internationale de la Mutualité*) specializes in mutual health and social insurance organizations. The ICMIF, (International Cooperative and Mutual Insurance Federation) is based in the United Kingdom and its members are mainly insurance co-operatives and mutual insurance companies. As of 2004, AISAM had 161 members, of which 8 are national associations, in 23 countries; AIM represents 45 national federations in 35 countries; and ICMIF had 133 members in 66 countries. Some overlapping (double membership) exists. In the case of AIM, of which the UTM is a member, members provide social coverage against sickness and other risks to more than 155 million people, either by participating directly in the management of compulsory health insurance or by offering supplementary, alternative or substitute coverage. In addition, there is an International Health Co-operative Organisation (IHCO), a sectoral organisation of the International Co-operative Alliance (ICA) that brings together co-operatives within the ICA membership that provide health care to their members, provide self-employment for health professionals (doctors, nurses, etc.) or integrate consumers' and producers' co-operatives. The IHCO has members from 11 countries and was founded in 1996.

[16] It is nonetheless remarkable that the government trusted –willingly or not—the task of implementing a national policy to a private (apex) organizations controlled by elected directives of the existing MHO. The government has in effect no legal means, other than regulatory, to enforce decisions upon the UTM whose Board of Directors is composed of delegates of the MHOs only, with no representation of the government in voice or vote.

Criticism of the UTM Approach

The UTM is subject to numerous and often strong criticism. While this criticism is relatively complex, it concentrates on the following key features:

1. A relatively high level of central power is given to the UTM with respect to MHOs and is related to its double role as a promotion agency and apex organization.
2. The creation of a standard Voluntary Mutual Health Insurance (VMHI) product.

A strong apex considerably reduces the freedom of the individual MHOs and gives the whole process a "top-down" character. Unusually for West Africa, the apex has created a standardized VMHI plan administered by the apex itself. The MHOs have the choice of adopting either this VMHI plan, through which most of the administration of the schema is performed by the apex, or an "*à la carte* health insurance (HI)" plan, adapted to the needs of the members of the MHO, but for which the administration falls largely on the MHOs' shoulders. Elsewhere in West Africa, MHO usually adopt only "*à la carte* HI" schemes.

Critics note that the VMHI plan is in reality a product of the UTM (the apex) and not of the MHOs. In our view, this is a wrong interpretation of the product. The product is not an UTM product per-se even though it was developed by staff of the UTM and its administration is delegated by the MHO to a special unit at the UTM. Yet, the residual risk related of the VMHI plan – just as that of the "*à la carte* HI" plans – is born mutually by members of the individual MHOs that adopt it (and *not* the UTM). Further, the standard VMHI plan is not sold by the UTM directly, although it has an aggressive marketing campaign to encourage the plan's adoption. As a mutual institution, by law the UTM cannot "sell" the product unless the client becomes a member of a MHO. The UTM cannot accept physical persons as members and thus cannot offer the plan. Individuals that request membership are referred to one of the MHOs affiliated to the Union.[17]

Critics also argue that the UTM has created "phantom MHOs," that is, MHOs designed to capture members that do not belong to any particular social group or community (e.g. town, enterprise, profession) and who located in urban areas in which the UTM has a the central or a regional office. These *Mutuelles Interprofessionnelles* will be presented later on. To the authors, the creation of such "generic MHOs" does not appear to be particularly questionable. Otherwise, it is difficult to see how these types of individuals/families can be received within the movement. The alternative is to turn them away. Many of these members have a stable income and allowing them to pay the premium regularly generates economies of scale for the entire system. The families of these members are benefiting from a plan that is superior to the statutory schema available in the country, whether they have access to it or not. It is difficult to agree with the critics when both parties – the system of MHOs and the families that would otherwise not have access to health insurance or access to a lower quality plan – are clearly benefiting from the creation of these MHOs. There is no evidence suggesting that doing

[17] The UTM could go one step further and still would not fall into unusual practices. A common arrangement among MHOs in industrialized countries is to transfer the *entire* risk at a second level pool, making the unions a "reinsurance union." Under this arrangement, the individual MHOs perform all marketing functions, keeping legal independence, and pay the union a reinsurance fee for carrying the risk. It is likely not a good idea to implement such a schema in the short term in Mali or any developing country. This is an arrangement that was introduced in industrialized countries only after many years of existence of the unions. However, there is scope for intermediate arrangements between no reinsurance at all and transfer of the entire risk to the union.

business with the middle class and resulting improvement in efficiency of the system has distracted the UTM from its main goal in a significant way, which is to bring health insurance to the informal economy, urban or rural. In fact, the pressure to reach sustainability is perhaps the main reason why the UTM is aggressively pursuing a market share in social sectors other than the informal economy.

The most important difference between the VMHI and the *à la carte* HI plans is in the way they are administered (besides their technical differences in terms of the type of risk and the amount covered). In the case of the VMHI, the MHOs forward the collected premiums to the UTM, which administers the funds for them and makes payment of claims. The operating surpluses or deficits belong to individual MHOs. In the *à la carte* HI approach, the collected premiums remain with (and claims are paid out by) the MHO.

In interviews with directors of the Telecommunications Co. Mutual Insurance Association, they expressed satisfaction in being able to offer the VMHI plan to their members who are employees of a state enterprise that also subscribe to the mandatory INPS plan. The MHO decided to offer its members the VMHI because it is superior to the INPS plan. The VMHI also presented a tremendous advantage since much of the administration was handled by the UTM, reducing the administrative work required of the MHO.[18]

Table 2.1 Insurance Organisation Basics

Issues	Observations
Legal structure	MHO: mutual association, members are natural persons UTM: second level association, members are legal persons (MHO)
Registration status	Registered *mutuelles de santé* in conformity with the Law
Regulation status	Regulated
Start of corporate operations	The UTM – i.e. the federation of MHOs – was created in 1996
Start of microinsurance operations	Same
Core business	Health insurance
Target market – core business	Informal sector
Target market – insurance business	No other product is offered
Geographic area of operation	Southern regions of the country including the capital, Bamako
Development, marketing, or servicing policies with other institutions	A network of contracts with service providers including primary health centres, regional and national hospitals depending upon the location of member MHO
Reinsurance provider, provider type	No formal reinsurance. However, MHOs pool reserves and there is a contingency fund under administration of the UTM of 25 MM CFAF (US$48,000).
Reinsurance type	N.A. However, a network anchored reinsurance scheme is under study. In this scheme, the UTM would provide reinsurance of a portion of the risk to member MHO.

[18] Throughout this case study report we note often the superiority of the VMHI plan over the one offered by the INPS. This is unavoidable. It is an issue that was raised often by MHO members with whom we had the opportunity to meet. For example, the INPS is based on its own network of dispensaries, the VMHI plan offers the health services in standard health facilities, which are much better equipped in personnel and materials. The coverage of key services such as pharmacy and specialized services by the INPS is unsuitable. Only "basic services" and maternity are covered by the INPS. In contrast, the VMHI plan –for reasons that will be exposed later on—is very comprehensive in its coverage.

Importance of the Apex

This difference in performance of both systems created in Mali – the one under the UTM sponsored by the MF and the one sponsored by the USAID through PHR – underlines the critical importance apex organizations play in creating the conditions for ensuring sustainability of MHOs. This is a phenomenon that repeats itself in Senegal, where, also under the initiative of the PHR, MHOs were created without attempting to develop the apex organization. As in Mali, these MHOs are having more difficulties than those created in cooperation with Mutualité Belge (MB), which were rapidly affiliated to an apex organization. Mutual institutions everywhere, including savings and loans mutuals, rely heavily on alliances (called unions, federations, leagues, etc.) to exploit economies of scale and control risks (from health service provision to government lobbying). As a rule, mutual financial intermediaries that remain isolated rarely succeed in establishing themselves, obtaining sustainability or in growing. This fact appears to be confirmed by the observations made in both Mali and Senegal regarding the MHOs created under the PHR schema of "stand alone" MHOs.

Box 2.2 Mutuality in Mali

Mutual associations are not new to Mali. The first mutual associations were created under the colonial administration. The Post and Telecommunications Mutual Association, the Catholic Mutual Association and the Cheminots Mutual Association were among the mutuals created during the colonial period. In the 1980s, other mutuals were created including the Education and Culture Workers Mutual Association and the National Guard Mutual Association.

Following the popular revolution of March 1991, the associative movement made great strides, with the mutuality movement also profiting from this new freedom of expression. Thus new mutual insurance associations were born. The Telecommunications Co. Mutual Insurance Association was created in 1992; the Students Mutual Insurance Association and the Craftsmen Mutual Insurance Association in 1996. Mutual associations created up to this time provided various forms of social coverage and some included health insurance. From 1996, the Mali mutuality movement engaged in the development of health insurance for the formal and informal sector, with a special focus on rural areas. Mali is the only country in West Africa with a mutuality law.

Yet the differences in centralization of power and administrative responsibilities of the UTM on one hand, and the *Union de Thies* (See Box 2.3) on the other, also reveal another subtler debate. In other West African countries (e.g. Senegal), the apex organizations have been designed and organized with a much narrower decision span over the functioning of its members, leaving individual MHOs a larger room of autonomy, but also a higher level of responsibility in the administration of insurance plans. In the case of the *Union de Thies*, for example, there is no standardized insurance product and all schemes are adapted to the particularities of the community in which they operate.

During interviews in both countries, management was questioned about the differences. They were both very aware of the different levels of integration, but they were both also convinced that they were using the right approach. Proponents of a more centralized approach argue that the centralization – and standardization of products – allows tasks that are difficult for the MHOs to perform, to be transferred to the apex organizations, exploiting economies of scale and increasing the efficiency and the reliability of the system. Furthermore, standardization has the additional benefit of providing the apex organization with more leverage in

negotiations with service providers. This is a major, if not the most important, source of uncertainty facing MHOs and is being addressed head on in the more centralized approach. Proponents of the more decentralized approach argue that adapting the products to the specific needs of the communities and allowing more autonomy for MHOs is important, and that strong apex organizations may not be sustainable.

Box 2.3 The "*Unions de Mutuelles*" in West Africa

The West African Region is probably the spot in the world with the most rapid growth in MHOs. MHO movements have started in Bénin, Burkina Faso, Cameroon, Côte d'Ivoire, Guinea, Mali, Mauritania, Niger, Sénégal, Tchad and Togo, and *Unions* (apex organizations) are following shortly after. Two other cases of this series report about these structures. The first is the *Union de Thiès*, which we could call the cradle of the movement in West Africa, after the creation in May 1989 of the first MHO in the community of Fandène (in the vicinity of Thiès, to the Northeast of Dakar). The other is the case study about the *Union des Mutuelles de Santé de Guinée Forestière* (UMSGF, CS # 17). But Unions de mutuelles exist in several other countries mentioned in the list above. These movements have a regional (West African) coordinating bureau that serves as a clearing and exchange of experiences based in Dakar, known as the "*Concertation.*"

At the heart of this debate is a question that is not unique to MHOs. Other mutual financial intermediaries (e.g. savings and loans cooperatives) face similar dilemmas regarding power ceded to apex organizations. There is little doubt about the long-term benefits of integration bodies for mutual financial institutions. They are essential to the long-term survival of the member institutions and a key lever in converting small local mutual institutions that lack economies of scales and technical skills into large and powerful movements that affiliate large portions of the population and offer a sophisticated range of products.

The question is how much integration and decision power should be builtinto apex organizations when, as in the case of Mali and the rest of West Africa, the networks are just incipient. Movements that choose higher levels of integration often face financial difficulties because the heavier apex structure, with its expanded functions of services provision, is expensive and beyond the means of the member institutions. Thus, they will rarely be able to function without an external subsidy. This is the case of the UTM and much of the critique it faces is related to this fact. At the same time, it is able to encourage the expansion of the sector and provide a more comprehensive set of financial services to members of the affiliated institutions. Mali chose a high level of integration, while the rest of Africa chose a lower level.

The founding MHOs of the UTM did not have much of a choice in this debate. Even if they have been allowed to decide for themselves back when the UTM was created, it is by no means sure that they would have chosen the road they are now pursuing. The development strategy implemented implied making the apex responsible for the provision of a large set of services, including expanding the movement throughout the country, by naturally giving it considerable powers to perform these functions. Along with this strategy came a subsidy that made it possible. Given a choice *now*, it is unlikely that member MHOs would want to reverse the process considering the performance of the UTM. Similarly, one can debate whether the MHOs of *Thiès* (or others) would follow the path of Mali's MHOs if they had faced the same conditions (an engaged government, a long-term subsidy to finance the apex, an engaged international partner and a mutuality law that provides support to the system). In

the end, it will be the relative performance of the different systems, and what will be learnt about the functioning of these apex organizations in West Africa that will determine which "model" (higher or lower level of integration) will find the favour of stakeholders.

Table 2.2 Insurance Organisation Basics - Trends

	2005	2004	2003	2002
Annual budget (US$x1000)	533	483	723	445
Total capital				
Number of member MHO	32	27	22	14
Total number of microinsurance policyholders (members)	10100	8600	6900	4400
Total number of microinsurance insured lives (beneficiaries)	39212	33400	26900	17300
Number of microinsurance staff	Mostly volunteers except for apex (UTM) staff with diversified insurance and MHO promotion functions			

2.2 Organisational Development

It is important to note that this description corresponds not to a single institution but to a network of institutions, composed of 32 MHOs affiliated to the apex organization, the UTM. Each of these MHOs is a legally recognized as a *mutual,* a separate institution owned by its members. MHOs are the primary insurance providers and they should not simply be viewed as branches of the UTM, legally and or in any other way. The UTM is a legally recognized as an independent institution and registered as a second-degree mutual institution, which is owned by member primary MHOs. Thus, the UTM is not just an association of MHOs, but a mutual in-itself with specialized functions that go well beyond representation of its member institutions. For this reason, the following description covers the two levels of the institution: the primary MHO and the secondary UTM.

Organizational Structure, Roles and Responsibilities

The Primary MHO. MHOs are statutory bodies according to the Mutuality Law No. 96-022 of 1996. The organizational design of Malian MHO is typical of mutual associations. It presents three structures with clearly defined and classical functions (see Figure 2.1-a). The following is the structure of the MHO of Cinzana. There are four governance bodies: the general assembly (GA), composed of all affiliated members, which is the supreme governance body with the responsibility of deciding on all strategic issues related to the functioning of the MHO. The GA appoints a Board of Directors that takes care of governance between meetings of the GA. The GA also appoints executive officers who assume responsibility for the day-to-day management of the MHO and form the Executive Committee – although this body is not officially mandated by the law. Three officers are typically appointed, the President, a Secretary and a Treasurer. Lastly, the GA also appoints a Supervisory Committee with monitoring and control functions. All officers and directors are volunteers and are prohibited by law to accept payments for exercising their functions.

Members of the Board of Directors of Cinzana reported that they spent between 2-10 hours per week in activities related to the MHO (administration, meetings, promotion and marketing, etc.). Some MHOs, especially those that are relatively large and offer an *à la carte*

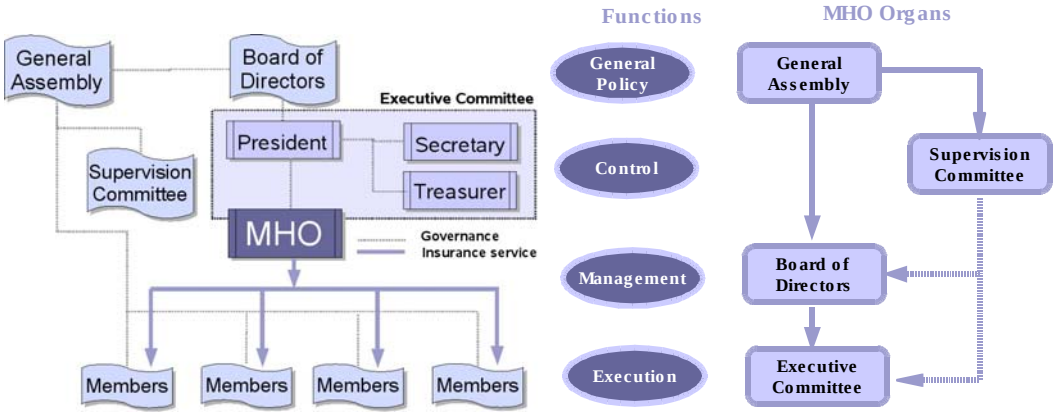
HI plan that requires local management of claims settlement may have an employee manager. Most MHOs that offer the VMHI do not need a local administrative capacity since the UTM handles most administrative matters.

Often MHO will create a structure of relays to insure the connection between the directors and management of the MHO on one hand, and its membership on the other. For example, the MHO of Cinzana chose to do so. In each village included in health districts in which the MHO has members, the association creates up to three relays. Each relay is composed of a President, a Secretary and a Treasurer. At least one must be a woman. These relays play a number of functions, including:

- ensure that premiums are collected in a timely fashion; the Treasurer transmits the funds to the MHO Treasurer
- organize local (village level) campaigns to promote membership in the MHO
- act as a link between members and management/governance of the MHO (e.g. announce a General Assembly)

The organizational structure of a MHO is given in Figure 2.1-a.

Figure 2.1 Organizational Structure and governance of a MHO



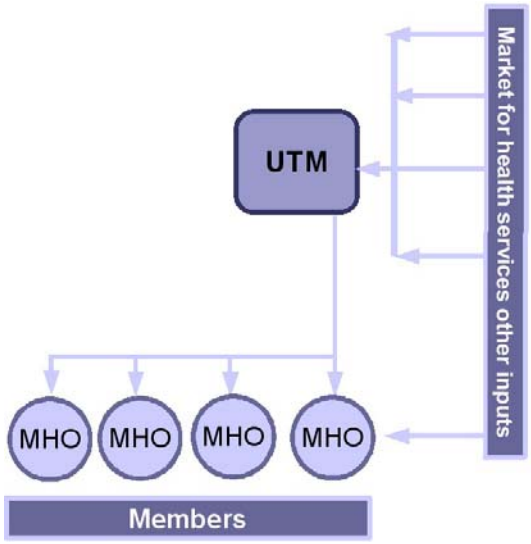
a) Organization structure b) Governance and Functions

A diagrammatic representation of the functions of each of the governance bodies of a MHO is given in the *Guide pour le développement de la mutualité au Mali à l'intention des agents de la tutelle*. In the *Guide*, the diagram is accompanied by detailed descriptions of the functions of each of the bodies and the officers. This diagram is presented in Figure 2.1-b.

The UTM. The Union Technique de la Mutualité (UTM) is a second level mutual organization according to the Mutuality Law No. 96-022 of 1996 and is owned by the first-level MHOs. It admits only MHOs, not people. Essentially, the UTM is the result of an alliance between first-level MHOs to create a structure that performs a number of functions. One central function of the UTM is to act as intermediary between its MHOs and several outside stakeholders, including the suppliers of different sort of inputs, particularly health services (mostly hospitals and health centres) as well as the government and other parties (the MF, *la Concertation*, etc).

A diagrammatic representation of the UTM as an intermediary between the market for inputs and services and the MHO is presented in Figure 2.2.

Figure 2.2 The UTM as the Integration Body of the MHO Movement in Mali



The UTM has several roles: [19]

i) It is the integration body to which most MHOs in Mali have affiliated and through which the movement coordinates its activities;

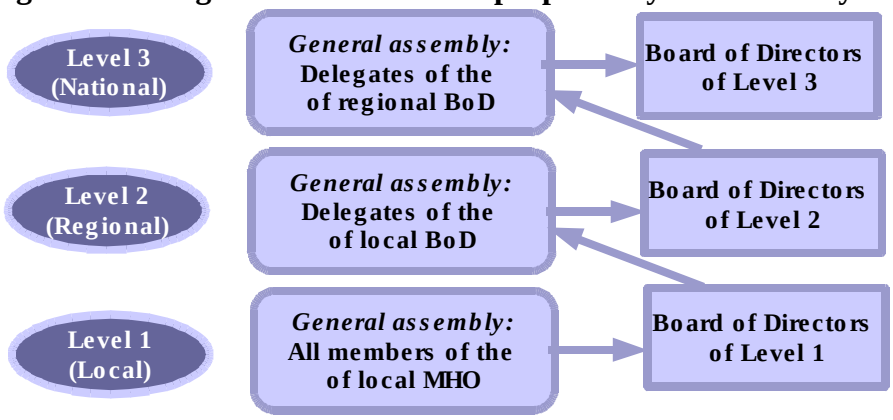
ii) The UTM is also a service unit for the MHOs in activities as varied as: supporting the development of new MHOs, performing feasibility studies required to obtain a licence, training personnel and directors, contracting health service providers for MHOs, developing new products, representing the MHO movement at government meetings, and ensuring that the legal and regulatory framework is supportive of MHO activities. These functions are continuously evolving as needs within the movement develop. Thus, the organization must be capable of performing functions of strategic planning and have adequate governance structures to make decisions that will adapt the alliance to changing conditions.

iii) The UTM also has a certain supervisory function since it maintains control over the operations of the individual MHOs. In fact, the UTM control is currently the only monitoring of MHOs, as the DPS has not implemented a consistent supervisory procedure. The DPS is only starting to have the staff necessary to perform this function.

The UTM is a two level structure: the individual MHOs and the apex. However, the legal framework allows for up to three levels. The governance of this – up to – three level structure is detailed in the *Guide* and is as presented in Figure 2.3.

[19] We focus here on the role of the UTM as an apex organization and not its function as an agency responsible for the implementation of a government strategy designed to bring health insurance to the urban and rural informal sector.

Figure 2.3 The governance structure proposed by the mutuality law



The network structure plays a key role in the development of the movement of MHOs in Mali. In fact, this network of small village and specialized group institutions would be impossible without it. For example, before the MHO of Kulikoro was created as part of the UTM network, a feasibility study of a stand-alone MHO was performed for the same association of artisan soap producing women. The study concluded that the minimum of 2000 paying beneficiaries was needed to make the institution sustainable, while keeping the premiums affordable for the women and their families. This was unachievable from the social point of view: the association could not have mobilized that many beneficiaries since a minimum of about 500-1000 adherent families were needed – a number this association was unable to mobilize. The association was composed of about 100 members and was thus unable to mobilize a larger population without the risk of facing severe adverse selection problems. Only the reduction of the break-even number of members, combined with a coverage that would include other local organizations, made the formation of the MHO possible. When the UTM was approached, it conducted a new feasibility study. It thus played a facilitating role in both reducing the minimum number of members through pooling of resources with other MHOs in Mali, and in the preparation of a feasibility plan that included other local organizations. The study revealed that as part of the network, the minimum number of members (beneficiaries) could be below 100 (400).

Management Skills

For individual MHOs, two types of management skills are required: management of the institution and management of the insurance product. With respect to the first, the UTM spends considerable resources in training before MHOs are created. In these sessions, directors and officers are trained in the principles of mutuality and in the management of the organization and its bodies (General Assembly, Board of Directors, etc.). A similar process is used to train officers and directors of the insurance product management. In the case of the MHO of Cinzana, members of the Board of Directors reported that once the association was formed and the officers elected, they received training in management of a MHO from the UTM. Training does not necessarily stop there. As needs arise, the UTM will organize "refresher" trainings. Further, the level of skills required varies. For MHO that offers an *à la carte* HI plan, officers must perform a wider range of activities since the product is managed locally.

Insurance Knowledge and Experience of Managers

At the level of the MHOs, one cannot really speak of receiving formal training in insurance concepts beyond what is offered by the UTM. MHOs are grassroots organizations that bring together people with very low social status (some of who are often illiterate). Furthermore, management of the associations is carried out by volunteers, even in the case of MHOs offering the *à la carte* HI plan. In both Cinzana and Kulikoro, for example, volunteers perform all management functions. Yet, volunteer directors and executives (president, secretaries, treasurers) are knowledgeable about adverse selection, moral hazard, fraud and over-billing, etc. They understood which product features served to control different forms of risk. Evidently, the information and training campaign had the desired effect. If these MHOs should run into difficulties, it will not be because they are not aware of the risks and are ignorant of the tools adopted by the UTM.

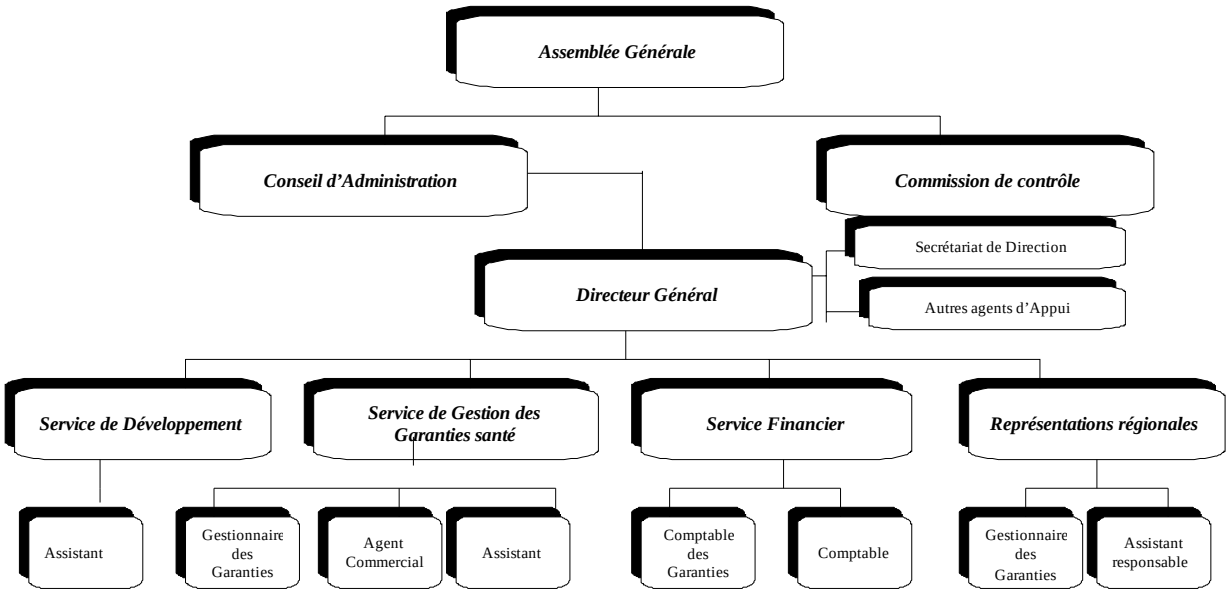
The UTM has highly competent and often specialized staff. Everyone responsible for the different programs would be able to stand up in the front of any audience and provide a detailed description of the virtues and risks of the products MHOs are selling. While it is true that the UTM is able to keep this qualified staff due to the subsidy it receives from the MF, there is no reason to believe that it will not be able to retain the same staff if it succeeds in achieving the economies of scale necessary to make the system sustainable.

The UTM is a body of highly trained and competent professionals including medical doctors (the Director General, Dr. O. Ouattara) accountants, information specialists and economists specialized in the field of health economics. Although there is not a complete separation of responsibilities, the personnel is divided into those with responsibilities for the management of the network and those that manage the VMHI plan. As a result, specialized and qualified staff in the offices of the UTM manages the VMHI plan. The *à la carte* HI plans, by contrast, are managed by volunteers operating the MHOs, who on average have a relatively low level of education.

As is standard in these network structures, particularly those that have undertaken a more intense integration, the UTM has a governance structure that supervises its activities as shown in Figure 2.3.

The governance structure of the apex is almost identical to the structure found in the MHOs. All MHOs have delegates in the General Assembly of the UTM. The GA appoints a Board of Directors (*Conseil d'administration*) and a Supervisory committee (*Commission de contrôle*). It also appoints a Chief Officer (currently *Directeur Général,* Dr. O. Ouattara) and other officers with executive functions. They are accountable to the BD and the GA. The Director creates other posts and departments for performing the responsibilities that he/she is given. In the case of the UTM, there are four departments or services: The Department of Development Services, the Department of Management of the Insurance Products Services, the Department of Financial Services and Department of Regional Services.

Figure 2.3 Flowchart of the UTM's Governance Structure



2.3 Resources

The UTM has 30 people including the staff in the Bamako central office (16), the staff in the regional offices and other employees (e.g. an agent stationed in one of the hospital most often used by MHO members). The UTM estimates that 70% of human resources are used in managing the different insurance plans ("standard VMHI" and "*à la carte* HI"), including training of volunteers and directors of the MHO, and 30% of the time for development and promotion work. Most MHOs have no employees and volunteers perform all work.

2.4 External Assistance/Relationships

The *Mutualité Française* has played a key role in the development of the system and is still a source of both technical and financial assistance. In particular, the insurance plans (the VMHI or the *à la carte* HI) offered by the MHOs were developed with the assistance of the MF. Starting in 1998, the MF and the French government have provided a subsidy that makes the continued work of the UTM possible. The UTM has also received and continues to receive support from the *Mutualité Belge*. This subsidy represented an average sum, over the last six years, of US$ 182,000 per year, over two consecutive "projects". While the ILO-STEP program has been less active in Mali, its work has had a positive impact on all countries in West Africa, including Mali. Using some simplifying assumptions and bit of algebra, this subsidy represents about US$7.5 per beneficiary per year, which is a quite small amount if one considers that according to the Millennium Development Goals, the average per year per capita foreign spending for a country in Africa should be in the region of US$25 to US$35. These funds are mostly investment since they have been used predominantly to create the existing first (MHO) and second level (UTM) institutional structure, which will support the

further development of the scheme. Over the same period, the current spending in health by the Mali government was US$11 per year per capita.[20]

2.5 Risk Management Products

The MHOs specialize in health insurance. In the spirit of mutuality and friendly societies laws, the products of these institutions are very narrowly defined. Most MHOs only offer health insurance. As noted above, a few mutual associations offer other social security products. Through the mutuality law – and as may be recalled from Section 1.2 above – Mali "mutuals," are specialized in social security products and are barred from offering other products such as savings and credit or any other type of insurance (casualty, life, etc.). Mali MHOs are just standard mutuals specialized in health insurance. Indeed, most but not all Mali mutuals are MHOs.

While from the perspective of an investor-owned insurance company, this restriction might be seen as extremely limiting for the interests of the company – in terms of profitability and risk management – this is not an issue in a MHO. The owners of these institutions are happy to focus on social security-related risks, in this case health, and engage the community in which they operate. Offering a diversified line of insurance products would require more abilities on the part of elected officials. Furthermore, it is unlikely that the community would be willing to participate, sharing in gains and *losses*, in an institution that would be opaque to them and that sells products the majority of members would not understand or need. The cost of managing the product line, governing the institution and preventing opportunistic behaviour would make the institution unattractive.

2.6 Profit Distribution and Investment of Reserves

Operating surpluses of the MHO are pooled into a common reserve fund of the UTM. The absence of capital markets limits investment opportunities; hence, reserves are on deposit in banks.

Individual MHOs have access to their own accumulated reserves to cover operating shortcomings. The reader should remember that the mutual contract implies that all members participate in both profits and losses, even if that requires out-of-pocket cash payments from members.

2.7 Reinsurance

The movement of MHOs has no formal reinsurance. However, a formal reinsurance scheme is being discussed. Currently, the UTM has a contingency fund of US$48,000 that was created in 2000 and has never been used. This reflects the fact that the risks have been appropriately covered by the MHOs. In other words, over the last five years, insurance payments have not exceeded premium income to the point that a MHO had to seek assistance

[20] Source: Sachs, J. D. "Can extreme poverty be eliminated?" *Scientific American*, 293, pp. 56-65. The figure of $7.5 was arrived to assuming that throughout the six years life of the UTM, the average number of beneficiaries was 25,000 members, a not too far off number considering that in 2006 number of beneficiaries strands at 45 to 50 thousands. The subsidy was obviously larger in the early years and is falling as membership rises.

from the contingency fund. Further, all operating surpluses of the individual MHOs are transferred and pooled under the management of the UTM. No individual MHO has accessed these reserves either.

One of the central problems with the implementation of a reinsurance scheme is that the UTM and the Union de Thiès – the Senegalese network of MHOs that is exploring a reinsurance scheme – are pioneers in developing countries, even though it is a common practice in industrialized countries. The re-insurance schemes that exist in several industrialized countries' mutual insurance networks are a useful guide, but are difficult to transpose to Mali (or Senegal). A number of differences, from the regulatory framework to the level of development of the network, make this transposition problematic.

Thus, both systems, the Mali UTM and the Senegal *Union des mutuelles de Thiès*, are exploring the concept and performing feasibility studies with the support of their foreign partners, which are mostly Belgian and French. The central question is what is the optimal arrangement of reinsurance for a network of MHOs such as the UTM. A number of questions arise, such as what should be reinsured (extreme insurance events, hospitalizations or other expensive services, shortcomings of cash flows), what should the cut-off point be when liability is transferred to the reinsurance fund, what should the minimum reserves for the reinsurance fund be, should the benefits of reinsurance pooling of risk be used to reduce risk or premiums, etc.

3. Members

Table 3.1 Client Information Table

Issues	Observations
Intended target groups/clients	Informal workers and rural communities
Actual clients and reasons if deviation from intended market	Same. Demands are being made on the UTM to pilot a system of MHOs that provide health insurance to formal sector workers. The reason for this pressure is the relative success and quality of the insurance plan offered by the UTM network to informal sector members
Exclusions of specific groups	None in principle. A MHO must exist to cover that particular bond. New MHO can be created any time – and is encouraged – with the assistance of the UTM.
General economic situation of clients	Middle class to rural poor. Extreme poor is likely not covered.
Key economic activities of clients	The whole range of possible economic activities, from the primary to the tertiary sector.
% of clients working in the informal economy	> 80%
Social characteristics of clients	From state employees to poor women informal workers
Geographic characteristics	Urban and rural
Nature of membership	Mutual membership
Methods of recruitment of clients	Door to door extension work by MHO members, town meetings to national TV campaigns orchestrated by the UTM.

3.1 Description of Social, Economic and Geographic Conditions

The members of MHOs range from state employees to groups of informal women workers producing artisan soap. One could say that members of MHOs constitute the entire range of population groups including formal and informal sector employees, full and part time workers, rural and urban dwellers, and women and men. Members are people who have access to an MHO – if they are lucky, one exists in their locality – or people who are covered by a state sponsored statutory body but choose to pay a second premium for voluntary health insurance. In other words, the movement of MHOs is penetrating every possible niche of Mali's society and is growing slowly, but steadily.

3.2 Familiarity with Insurance Prior to Enrolment

For the most part, the majority of members of a MHO initially had no precise understanding of health insurance. It is exceptional that a group or an individual will present itself to the UTM or one of its MHOs with a clear idea of the product being offered. These exceptions are usually individuals that benefit from one of the statutory health insurance programs, are unsatisfied with it, and have heard that the UTM is offering a better product.

The usual situation is that either the UTM itself, or another organization (an NGO, or more frequently a health center) encourages people to get informed about the benefits of mutual

health insurance and encourages them to approach the UTM, either through a member MHO or one of its regional offices. Individuals become aware of the nature of the product only after the UTM organizes information sessions. At that moment, it is decided whether a more extensive consultation at community level about creating a MHO is needed and whether a more detailed study should be performed.

In the case of the MHO of Cinzana, the UTM met different groups of the community for a week before the general meeting that led to the creation of the association. The Board of Directors expressed that they understood the insurance product offered by the association. They noted that it is rare that they are not able to provide a suitable answer to questions posed by members or prospective members. However, they also believed that within the membership, there is a considerable level of variance in the understanding. They also observed that with the passage of time, there has been a considerable increase in the understanding of the product, and this is also true for members and non-members living in the health district of Cinzana and some of the surrounding localities.

From UTM's experience, mutual health insurance coverage does not grow spontaneously. For the vast majority of people, seeking health insurance is not a natural response. Rather, it is the result of information provision explaining the advantages of health insurance over other informal and spontaneous risk management mechanisms (tontines, borrowings, savings, etc.), and most importantly, why premiums are not reimbursed when insured events do not occur. This information provision also involves explaining the nature of "mutual insurance" as a mechanism through which the risk of individuals is spread over and borne by the entire community of "policyholders", who share losses and profits pro rata. However, once a community has become informed about health insurance and created a MHO, the members of the organization are the ones who continue the work of providing information to new potential members. It is in their interest to do so since this activity strengthens their MHO, increasing its likelihood of survival, increasing its leverage with the local health service providers and spreading out its fixed costs.

4. The Product

Table 4.1 Product Details

	Product Features and Policies
Microinsurance Type	Health (complementary): the co-payment required by the public health provider.
Group or individual product	The product is sold to individuals who participate on a voluntary basis. However, there is a certain social cohesion at the level of the MHO (enterprise, locality, profession, activity)
Term	N.A.
Eligibility requirements	Be member of the MHO. Membership on mostly regional (an *Aire de santé*)[21] or other criteria.[22]
Renewal requirements	Be up to date with premium payment (see premium collection arrangements)
Rejection rate	0 %[23]
Voluntary or compulsory	Voluntary
Product coverage (benefits)	Depending upon plan adopted by the individual MHO. There is a standard Voluntary Mutual Health Insurance (VMHI) plan (divisible in two); and several "*à la carte* Health Insurance" plans adapted to the needs of particular MHO. We present a basic schema in Figure 6.
Key exclusions	None for diseases for which co-payment is necessary
Pricing – premiums	For the *standard VMHI* plan: 1. Basic health (*soins ambulatoirs*) at 210 CFAF (US$0.41) per month per person 2. Hospitalization (*hospitalisation*) at 270 CFAF (US$0.52) per month per person 3. The Combined (*combine*) at 440 CFAF (US$0.85) per month per person for both. A recent modification to the plan includes ophthalmology and dentistry. This resulted in an increase of 20 CFAF (US$0.04) to include these two services in the Combined plan. For *"à la carte HI"* plans: variable rates depending on coverage, co-payment. Payment of premium is individual for all members of the family[24]

[21] An *Aire de santé* is an administrative unit for purposes of public health management. An *Aire* includes in principle a health centre (*Centre de santé* or ASACO) with a medical doctor and covers a territory with a radius of 15 Km from the health centre. Not all *Aires* have a health centre although one is planned for each district.

[22] In the case of the MHO of *Kulikoro*, the original criteria was to belong to a women's association. Membership has been opened since becoming a MHO with a regional membership vocation.

[23] This is hard to believe. Yet we were not able to identify in the several MHO visited a single case of somebody being denied membership, nor were members interviewed aware of any one being denied membership. Membership is automatic upon demand and payments of registration fees, i.e., membership is not scrutinized or approved by the executive committee. The question of adverse selection naturally rises. We will discuss mechanisms used to control adverse selection later on. Obviously, the mutual nature of the contract plays a key role in ensuring access once a candidate meets the bond criteria.

[24] The premiums vary considerably. The most expensive plan is the standard VMHI plan. "*À la carte* HI" premiums vary. In the case of the Cinzana MHO, the premium is 1150 CFAF (2.22 $US) per year per

	Product Features and Policies
Pricing – co-payments and deductibles	*VMHI:* 1. Basic health (*soins ambulatoirs*) 60% of all pathologies. 2. Hospitalization (*hospitalisation*) 70% for hospital charges. *À la carte HI:* Other arrangements are possible depending on local needs and preferences.
Pricing – other fees	Registration (for membership) or for re-registration after having fallen behind in more than two payments (generally, special arrangements exist). The registration fee is of approx US$ 4.50.

Notes: (*)

Table 4.1 reveals that there are basically two types of products: one standardized product, the Voluntary Mutual Health Insurance (VMHI), which is offered by some MHOs, particularly urban institutions and institutions affiliated to enterprises, and the a series of *à la carte* Health Insurance plans for (mostly) rural MHO. The list below presents the MHO that are offering the VMHI plan, and some statistics related to them:

Table 4.2 List of MHO offering the VMHI plan. May 2005

Name	Members	Beneficiaries
Mutuelle de la Poste	625	1588
Mutuelle de Santé de San	85	200
Mutuelle Interprofessionnelle du Mali	2222	6130
Mutuelle des travailleurs de l'Education et de la Culture	552	2027
Mutuelle des Artisans du Mali	563	1449
Mutuelle Interprofessionnelle de Kayes	436	1528
Mutuelle des Etudiants et Universitaires du Mali	13	17
Mutuelle SUNDJIYA de Kéniéba	169	669
Mutuelle des Travailleurs de la SOTELMA	394	1240
Mutuelle Interprofessionnelle de Sikasso	394	1240
Mutuelle Djiguiya de Koulikoro	177	580
Mutuelle des Travailleurs du PMU-Mali	237	799
Mutuelle du trésor	90	160
Mutuelle de santé de Kati	17	45
Mutuelle Interprofessionnelle de Ségou	1041	2406
Amical de la Mutuelle de la Police		
Mutuelle Pari-Sin des femmes de Kanandjiguila	91	183
Mutuelle des Administrateurs Civils	68	204
Mutuelle des travailleurs de la Mairie de la Commune II	67	196
Mutuelle Interprofessionnelle de Mopti	45	193
Total	***8036***	***23 376***

In this list, the *Mutuelles Interprofessionnelles* (de Mali, Kayes, Sikasso, Ségou and Mopti) are "generic MHOs". They are designed to attract members, mostly in urban areas, that do not belong to any particular social or economic group. Through these MHOs the UTM is competing directly against other health insurance plans, attracting professionals and employees of enterprises, some of whom are already covered by the INPS plan. As the table

beneficiary for a plan that covers primary health care at the local health centre plus secondary (hospitalization) health care.

reveals, these MHOs are among the largest and are a steady source of premium income to cover administrative expenses.

4.1 Partners

There are essentially three partners that play a key role in the development of MHOs and their health insurance services:

1. The health service providers
2. The international partners : the *Service de Coopération et d'Action Culturelle de l'Ambassade de France*, the *Fédération Nationale de la Mutualité Française, l'Alliance Nationale des Mutualités Chrétiennes de Belgique* and *Le fonds Belge de Survie*
3. Other local financial institutions

Perhaps another "partner" that may be mentioned is the government. However, we already described this relationship in previous sections covering the role of the government as a promoter of the scheme and as a regulator.

The Health Service Providers

The most important partners of the UTM are health service providers. To start with, the service providers are the other main component of the process of financing (the MHOs) and service provision (the health centres and hospitals). There is a symbiotic relation between these two structures. Most MHOs are structured around a health centre (*aire de santé*) that delivers services to the members of the mutual. At the same time, the health centre benefits from the presence of the MHO by ensuring that the local population has the financial means to cover the co-payment required under the BI approach of health service delivery.

In all the visits made, the MHOs constantly referred to the close collaboration that existed between them and local health centres. The expression used to describe the relation was "partnership" (*partenariat*). In some cases, the financial resources made available to health centres were so important that they were able to engage in investment programs to acquire medical equipment that would not have been possible in absence of the MHO. It is not common for the MHO to have an office in the building of the health centre. In the hospital that is most often used by the beneficiaries of the network, the UTM has stationed an agent who supervises the traffic of members, the delivery of services, and ensures that all charges are correct, and that all accounts between the hospital and the UTM are settled.

Secondly, the UTM sees the health centres and hospitals as "strategic" partners since they often play a central role in the creation of a new MHO. On several occasions, health centres have approached the UTM, noting difficulties among members of the community to face co-payments for health services. These centres have thus asked the UTM to undertake the promotion of a new MHO and collaborated actively with it. These centres have actively helped in transmitting information and in encouraging individuals to join MHOs.

These relationships are established very carefully. The typical negotiation period – from the moment contacts with the service providers are established to the moment the agreement is

signed – is one full year. The UTM has developed a model contract, which is used by practically all MHOs to regulate their relationship with local health centres (with small adjustments to adapt to local situations). This contract establishes the obligations for both parties, notably the standards of quality in heath services and the specifications of the insurance coverage.

This partnership did not develop spontaneously. For some time, health service providers dismissed the MHOs as irrelevant, refused to accept the insurance coverage, overcharged and ignored the contractual arrangements made between them and the UTM. However, the consolidation of the movement, its growth, and the public's increasing exposure to it has changed the perception of service providers. This has lead to the development to a trusting relationship between the service providers and the UTM or the local MHO.

The relationship is not problem-free, but it is becoming less problematic. The partnership works best at the level of the health centres offering basic health services. It becomes more difficult with institutions that are higher up in the hierarchy of the country's health delivery system (e.g. regional hospitals). The reasons for this are quite simple: (i) basic health centres have more intimate contact with the communities in which the MHOs operate, and its personnel is aware of the vital role the mutual plays in financing care and the health centre itself; and (ii) among secondary health providers, there is a higher mobility of personnel. As a result, members continuously face individuals and employees who are not aware of the MHO or the way this relationship works.

Further, doctors at the secondary level are some times dismissive of the list of "generic drugs" allowed in the agreements between the UTM and the service providers. Thus, they often prescribe drugs that are not covered by the plan and for which the UTM refuses to pay. It is not unusual that doctors exert considerable psychological pressure on members of a MHO to accept non-generic medicines, under the prodding of drug companies, and encourage members to argue with the MHO to pay for the more expensive drugs.

According to the standard agreement employed by the UTM, it is responsibility of the health provider to adhere strictly to the standards established by the plan. In not doing so, the service provider risks not being compensated by the UTM. In 2003, the problem had become serious enough that the UTM was forced to request the Public Health Ministry to enforce the policy of using generic drugs at public health facilities. The UTM has, however, engaged a medical doctor who evaluates specific situations in which health service providers have insisted on the use of a non-generic drug. If this professional considers that the deviation from the policy is justified, then in most cases the UTM agrees to compensate the service provider.

The International Partners

As noted in the history of the UTM, the MF has been key to the development of the system. The MF has played a central role providing the technical expertise and the financing necessary to obtain the institutional design of the UTM, the line of products offered and the feasibility studies necessary to put the pieces of the puzzle in place. In particular, the insurance plans offered by the MHOs were developed with the assistance of MF. Currently, the MF and the French government provide a subsidy that makes the continued work of the UTM possible. The UTM also receives support from the *Mutualité Belge*.

Other Local Financial Institutions

The UTM collaborates with other local financial institutions, particularly those of mutual nature. This happens at two levels. At the *local* level, the MHO deposits its funds and conducts financial transactions through the local financial cooperative. The Cinzana MHO, for example, works with the local financial cooperative belonging to the Nyesigiso network.[25] At the *national* or *regional* level, the UTM is discussing the provision of health insurance coverage for members through a modality that has not yet been established with these networks (e.g. the Kafo Jignew and Nyesigiso networks). The importance of this project for the UTM is obvious since it would allow the extension of the program to a large basin of potential customer/members.

Specifically, the UTM has been working with Kafo Jiginew in the south of Mali (the "circles" of Kadiolo and Koutiala). There, the staff of the regional UTM office of Sikasso and the regional offices of Kafo Jiginew have visited several *aires de santé*, to assess the feasibility of creating MHOs that would seek as members individuals that are also members of a Kafo Jiginew *caisse popularie*. The focus was on *aires* with *caisse populaires* presenting good performance indicators, with a strong sense of community life and a favourable predisposition to the creation of a MHO. Of nine *aires* visited, five have been selected for further work designed to prepare the ground for the creation of a local MHO.

4.2 Distribution Channels

The Channels Utilised

The distribution channel is strictly through the local MHOs. The UTM does not "sell" insurance but offers mutual health coverage to affiliates of member MHOs. The MHO of Cinzana draws its membership from the health district of the same name. This health district covers a population of about 13,000 persons in several villages (including Cinzana).

Their Effectiveness

There are two sides to the "effectiveness" of a distribution channel. On one side is the celerity with which services can be offered to new "clients," and on the other is the retention of existing "clients." With respect to the first, one could say that distributing insurance (whatever type) through mutual organizations is not a very efficient mechanism. It is much easier for a capital-based insurance provider to "sell" insurance to a particular target population than to create a mutual organization, which is a very involving process, even if a well-established grassroots organization already exists.[26] If this grassroots organization does

[25] Mali benefits of seven networks of *caisses populaires* (financial cooperatives) with about 350 member institutions. These the two largest are the Kafo Jiginew and Nyesigiso networks with 129 and 50 member institutions respectively, with a joint total membership of 250,000 member persons. In total, the seven networks provide financial services to about 340,000 members and their families.

[26] In the case of the MHO of Kulikoro, the association was created after several years of trying and planning. Elsewhere in this report we have reported about the failed attempt to create an MHO in Kulikoro before the UTM existed—failed due to economies of scale problems—and its subsequent creation under the UTM. Despite a grassroots organization, an association of women workers involved in the production of soap from seed residues of the local cotton mill, and a strong will to create the MHO, it was not possible until the UTM could pool resources and exploit economies of scale at the network level, making the local MHO of Kulikoro feasible.

not exist, even more effort is required since it is unlikely that the MHO will develop in the absence of a minimal level of organization and a certain "bond" at the local level.

MHOs however are hard to match in their capacity to create stable (mutual) insurance markets. The entire organization is supported and managed by the target community. Grievances with the product are easily identifiable through the representation/governance structure of the MHO and the sheer proximity of the "clients" (including the fact that everyone responsible for governance and management is also a client). This allows for a continuous assessment of the suitability of the product, and it is fully within the power of the MHO to modify the product should the need arise. Thus, MHOs have the advantage that beneficiaries of the insurance plan have full control over the technical and financial aspects of the product and the organization that distributes it. To this, it is possible to add the benefit, noted elsewhere but worth emphasizing, that a MHO is a highly efficient mechanism to operationalize part of the *Bamako Initiative* – that of giving users a say in the management of the provision of health services. Thus, the MHO is a highly efficient mechanism of distribution of *both* health insurance and health services.

Rejections

Typically, all persons satisfying the criteria that define the mutuality "bond," have right to membership. The "bond" will change from institution to institution. In the case of the four MHOs visited, in each the "bond" was different. In the Cinzana MHO, the criterion was to live within the health district (*aire de santé*). In the Kulikoro, the initial criterion was to be a member of the women's association (of soap producing workers). However, this criterion was being opened up to include the entire community in the health district (as in the case of Cinzana). In the Post Office MHO, the criterion is to be employed by that state enterprise. Finally, in the case of the Professionals MHO of Segou, the criterion was to be an independent or employed worker in the locality.[27] It is in the interest of the members – and the MHO's directors – to ensure that this rule is respected to avoid adverse selection problems that will be costly for the current membership.

Eligibility is usually at the family level. Once a family head is eligible for membership, all members of the family are eligible to become beneficiaries. In exceptional situations, an MHO may accept members from outside its defined bond (e.g. another town), usually due to one of three reasons: i) absence of a health centre in the district, ii) absence of a critical mass of individuals to create an MHO in that locality; or iii) on a temporary basis during the process of creating another MHO. Members are rejected or expelled only in the case of fraud.

During visits to Kulikoro and Cinzana, members were pressed to recall a case of rejection within the last few years, and none were reported, nor could they think of a reason – other than past fraud – why a person's or family's application would be rejected provided that they met the "bond" requirement (locality, enterprise, profession, etc.).

The absence of rejections is undoubtedly good for the community and their access to health insurance. It is also a reasonable policy in a period of expansion, especially if the goal of achieving a break-even point is pressing. However, it is doubtful that the MHO will be able to

[27] The reader should recall that a "Professionals MHO" is somewhat of a catch-all organization setup in urban areas of the country, often with strong support and monitoring by the regional offices.

sustain this liberal policy of accepting everyone in the long run. Traditionally, mutual health – and other form of social insurance – schemes in most places of the world have relied heavily on selecting individuals by criteria of "moral integrity" (however, this was defined in the specific contexts, with strict procedures of referrals by older members and selection committees in place).

4.3 Benefits

Role of Insurance in Meeting Institutional and Client Needs

The typical coverage is on all health services offered by the local health centre in the *aire de santé,* hospitalization up to a limited number of days and analysis. These are all the services for which there is co-payment required by the state according to the Bamako Initiative (BI) standards (see Box 1.3). Variations from one plan to the other are mostly in the percentage of co-payment covered – the residue consisting of the deductible. A common level of coverage is between 60%-75% of the co-payment required according to the Table in Box 1.2. As noted in Table 4.1, the standard VMHI coverage is for basic health (*soins ambulatoirs*) 60% of all pathologies covered in the local health centre and for hospitalization (*soins hospitaliers*) 70% for hospital charges. *A la carte* HI arrangements depend on local needs and preferences expressed by members in the design of the plan. In the case of a MHO that adopts an *à la carte* HI plan, typically the plan is decided by the community on the basis of a limited set of options that trade-off premiums with coverage. The procedure for plans will be described in detail in Section 6. To accommodate payment capacity of members, the plans have been adapted to cover those events that the members consider most important, considering their own payment capacity. Thus, throughout the remainder of the document, when we mention a percentage, it usually refers to the co-payment for all pathologies listed in Box 1.3.

Even the standard VMHI plan presents some flexibility. An MHO can adopt the primary health plan alone, the secondary health plan alone, or the combined plan. Further, the MHO may add coverage for ophthalmology and dentistry to the combined plan. In practice, different MHOs have adopted different combinations. The MHO of Kulikoro, for example, adopted the primary health care plan alone. The Telecommunications Co. MHO adopted the combined plan with the ophthalmology and dentistry rider.

The question may be raised whether the population is able to afford the deductible – which typically varies between 25%-50% depending upon plans. The personnel of the UTM and leaders of the MHO interviewed during the visits did not go as far as saying that the problem of accessing health services had been eliminated completely. However, they were confident that access was dramatically improved for persons who had no previous access to insurance, and improved access was an attractive feature for others who are choosing to join an MHO even if they already have coverage through a statutory health insurance plan.

Efforts to Address Special Needs of Women and Children

As noted below when discussing adverse selection, MHOs strongly encourage affiliation of families, although they do not necessarily require that every family member becomes a beneficiary. For example, for the standard VMHI plan there is an average of three beneficiaries per member (3:1), varying between 2:1 and 4:1 on average for individual MHOs offering the plan. In MHOs with *à la carte* HI plans, often based in rural areas, the ratio tends

to be higher. This policy of family affiliation is not just a device designed to prevent adverse selection, but a choice by members in the design of *à la carte* plans and expressed by participants in focus group discussions in the design of the VMHI plan.

Beyond this basic policy of family affiliation, efforts to meet the special needs of women and children depend on the needs expressed by MHO communities. For example, in a cotton grower MHO dominated by men in the region of *Sikasso* (the south east), the *à la carte* plan completely covers maternity expenses; and 75% on wife and children of members up to age of seven years and 50% coverage for male members. The premium of this plan is CFAF 2000 (US$ 3.63) per year per beneficiary. In the case of this MHO, affiliation is not by family but by farm. A typical farm will be exploited by several households, which in turn will include parents, children and even those children with their own family. The health insurance coverage takes care of the entire economic unit including all persons involved in the operation of the farm. This was not always so. The MHO started with a plan that covered women and children only, given their low purchasing power. However, improved economic conditions in the community has allowed to extend coverage to men (to 50%) and gone beyond the farms to cover the entire local community including indigents. Towards the end of 2005, the total of beneficiaries covered by the MHO reached 3000 persons.

Table 4.3 VMHI plan beneficiaries by gender

Year	Sex of Beneficiary	Number
2001	Men	1 519
	Women	1 579
2002	Men	3 689
	Women	3 833
2003	Men	7 264
	Women	7 338
2004	Men	9 096
	Women	9 590
2005	Men	10 871
	Women	11 124

Thus, discrimination against women and children does not appear to be an issue. In fact, in some cases – like in the MHO of *Sikasso* – there is even favourable discrimination. Further, maternity is probably the type of health service that is most consistently covered and with the highest percentage.

4.4 Premium Calculation

In the case of the *à la carte* HI plans, premiums and their calculations vary substantially. The actual cost structure combining base units and apex, does not reflect the current level of activity since it has been designed for a larger insured population, to which we must add the promotional activities in which the UTM engages. Perhaps, to obtain an estimate of projected steady-state costs, we can provide the projected breakdown of costs at a level of 50,000 beneficiaries covered by the standard VMHI plan. This cost breakdown is summarized in Table 4.4. For *à la carte* HI plans, the breakdown of charges depends on the plan, the local costs structure and the benefits covered by the plan.

Table 4.4 Premium Calculation

Designation	Amount	Percentage
Technical cost (benefits)	300	65%
Management UTM	86	19%
UTM affiliation fees	40	9%
Reinsurance	6	1%
Guarantee	3	1%
Reserve	25	5%
Total	**460**	**100%**

4.5 Premium Collection

The premium collection process varies considerably across the UTM network. For both, the standard VMHI or the *à la carte* HI plan, collection of premium tends to be adapted to the idiosyncrasies of the income stream of the community where MHOs operate. In some cases, the premiums are deducted directly from the payroll (the Telecommunications Co. MHO). In a "professional" MHO, members send or deliver their payments on a monthly basis. In yet other cases, members pay the premium at the moment of the harvest once or multiple times in the year, depending on the crop distribution (e.g. the seasonal payment after the cotton harvest in the south of Mali).

Members of the Cinzana MHO reported that they had the choice of paying the premium annually (1150 CFAF = US$2.10 per beneficiary per year), bi-annually or quarterly (always in advance), although the preference is for annual payments. The MHO covers several villages in the health district. The MHO of Cinzana is one of the associations with relays. These relays facilitate collection of premiums by reminding members and collecting funds. The Treasurer of the relay transmits the funds to the central office in Cinzana, which in turn deposits these funds in the local Nyesigiso (financial) cooperative.

Non-renewals are, of course, a continuous threat, particularly when economic conditions deteriorate. This is recognized across the West African region as one of the most serious problems influencing the sustainability of MHOs. The West African region, and Mali in particular, is both poor and has a very fragile environment due to macro factors, including international prices of commodities, weather, natural disasters and pests.

The Cinzana MHO had been providing coverage of health services for a period of 16 months at the time of the interview. According to members of the Executive Committee, no member had failed to pay the premium. This is no doubt an exceptional case. The Kolikoro MHO is known within the UTM to be one that has most difficulties in maintaining premiums up to date.

In general, MHOs in Mali (and West Africa in general) strongly discourage arrears in the payment of premiums by the simple – however ruthless – mechanism of cutting off coverage to members that are not up-to-date with payments. Practices of Friendly and Fraternal Societies, current and past, in industrialized countries are considerably more lenient than those observed among West African MHOs. For the most part, they will allow a member to eliminate arrears and regain coverage within a reasonable amount of time, say three months,

after which they lose membership. To regain membership, the person must go through the complete steps of a new affiliation (including obligatory waiting times). This, rather tough, policy is designed both to discourage arrears and opportunistic behaviour by members such paying only when coverage is needed.

4.6 Claims Management

Claims Settlement Process

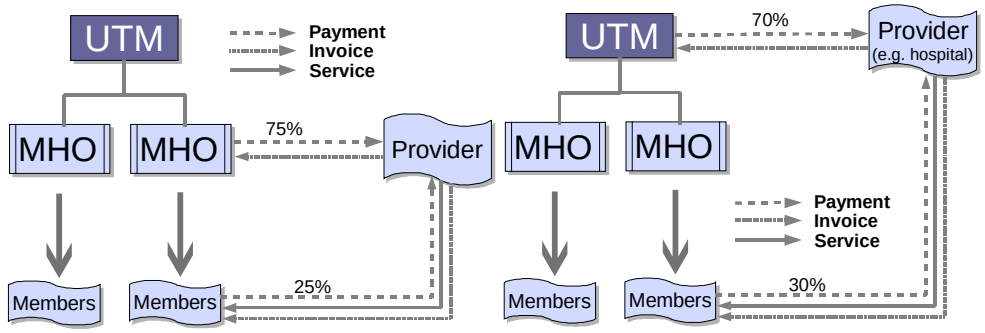
The claims settlement procedure depends on whether the MHO offers the VMHI plan or an *à la carte* HI plan. The difference is not in the procedure itself, but in the parties involved. The difference is due mostly to the fact that the VMHI is managed centrally by the UTM, while most activities related to collection of premiums and settlement of claims of *à la carte* HI plans are managed by MHOs. For this very reason, there are local variations in the process of collection and claims settlement in MHOs offering *à la carte* HI plans. However, the trend is towards a relatively standardized approach, even for the latter plans.

Claim Settlement in the VMHI Plan

The claims settlement procedure under the standard VMHI plan could not be simpler. Take, for example, a hospitalization: The member pays the 30% deductible of the co-payment required by the state to the service provider (or as used in French, the *tiquet modérateur*) and the health service provider bills the UTM for the remaining 70%.

Identification problems are avoided through the use of a photo-membership card as evidence of coverage. These membership cards allow the access of the members to any of the points-of-service of the system, while respecting the pyramidal structure of health provision: local basic health service centres and hospitals. To insure that only members in good standing are provided the service, the UTM circulates the list of members eligible for health services to all point of services with which the UTM has an agreement at the beginning of each month – usually all institutions in a region. At the hospital – or secondary health provider – level, fraud is controlled through referrals by the primary health centre. At the hospital used most often, an employee of the UTM is deployed on site in charge of all administrative aspects, from identification of beneficiaries to payment of claims to the service provider. The claim settlement process is illustrated in the diagram of the Figure 4.1.

Figure 4.1 Claims Settlement



a) the *à la carte* HI plan b) the standard VMHI plan

Claim settlement in the à la carte *HI Plans*

Although variations exist, most procedures are similar to the one used in the standard VMHI plan, with the difference being that settlement is carried out by MHOs instead of UTM. The health facility has information about the identity of the beneficiaries provided by the MHO, in addition to which the member must present evidence of the coverage agreed between the point-of-service and the MHO – usually a membership identity card (of the head of the family) and a beneficiary card. At the end of the month, the points-of-service submit claims for services provided to the members of the organization to the MHO.

Common reasons for delays

There are usually no delays in payments to health service providers. There is a high level of awareness that a good relation between the MHO and the health centres is essential. For this reason, both parties have developed a reasonable level of discipline in meeting their obligations.

Major reasons for rejection

Given the procedure described above, the claims are not rejected at the level of the members but at the level of the point-of-service. In order words, a claim made by a service provider may not be honoured by the MHO, even though the service was provided, if it was not done according to standards agreed between the provider and the UTM. The main reason for rejections is the use of medicines or procedures not covered by the plan. This happens almost exclusively at hospitals where the medical personnel is less informed about UTM standards or are more inclined to prescribe unofficial medications.

Table 4.5 Claims Settlement Details

Issues	Observations
Parties involved in claims settlement	*Standard VMHI:* UTM and health service provider. *à la carte HI:* MHO and health service provider.
Documents are required for claims submission	Beneficiary must present identity card to the health service provider
Claims payment method	Direct payment to the health service provider
Time from insured event to claim submission	End of month
Time to pass through any intermediaries	N/A
Time from submission to payment	A week
Claims rejection rate	Negligible

4.7 Risk Management and Controls

The MHOs of Mali are exposed to all major forms of risk. However, resulting from their very nature as mutual institutions, and through a series of mechanisms that have been built into the insurance plans, they appear to have a reasonable control over the major forms of risk. Some of the clearest evidence of this is that, although UTM has in place a contingency fund of 25 million CFAF, there has been no demand for it as a result of risk during its five years of existence.

Moral Hazard

Moral hazard is a subtle source of risk and one that is particularly difficult to control. Furthermore, some standard mechanisms to control moral hazard are not available to MHOs: refusing coverage to individuals that are perceived as being individuals that may display overly risky behaviour, use of risk-adjusted premiums and periodic renewal of the policy with rating evaluation. However, other mechanisms are available to mutual institutions: social monitoring of risk. The MHOs of Mali control moral hazard through:

i) co-payment[28]
ii) standardized medical procedures and generic drugs
iii) limit services to imprudent or negligent behaviour by members
iv) direct monitoring

Co payment: Members share in covering the cost of health care services. The co-payment ranges between 25% and 40% of user fees, according to the principles of the BI (see Box 1.3). Further, while the insurance covers these participations, it does so up to a 75%.

Standardizing medical procedures: Another moral hazard mitigating mechanisms is the coverage of only standardized medical procedures and generic drugs – the provision of which is encouraged by the BI. These are controlled by agreements. Ensuring that these agreements are respected is more difficult in small rural communities that have adopted a *à la carte* HI plan and are thus responsible for the administration of the plan. However, it is in these communities that the MHOs are also able to use compensatory mechanisms such as direct monitoring and social pressure on deviant members. In urban MHOs that adopt the standard VMHI plan, the UTM administers the plan. There, respect of the agreement between the MHO/UTM and the service providers is closely scrutinized for compliance.

Limit services to imprudent behaviour: MHOs also employ controls to prevent imprudent or negligent behaviour by members. In some rural MHOs, procedures have been introduced through which complications in pregnancies that need patients to be transferred to a secondary health service organization (hospital) will only be covered if the mother has gone for least three checkups a the local health centre during the pregnancy. Equally, several MHOs have introduced a mandatory vaccination scheme for newborns. Infants that have not been vaccinated will not be covered should they develop one of the diseases that the vaccination program was designed to prevent.

Direct monitoring: Finally, in rural areas with their relatively close social relations, direct monitoring by members is a powerful mechanism to control moral hazard. Members are fully aware that this type of behaviour can put the MHO at risk of failure with the consequent loss of the insurance coverage. The governance structure – general assembly and board of directors – disciplines members that are patently abusing the system. Meeting of these bodies

[28] The expression used in French West Africa to refer to co-payments is *ticket modérateur*, which literally means "moderating ticket" in the sense of encouraging moderate behaviour. Whether a deductible is optimal in health insurance is a point of theoretical and empirical debate. While the trend in practice is towards increasing deductibles, theoretical arguments suggest that this may actually be negative for the insurance provider since it tends to discourage preventive medicine.

have the function of electing officers and supervising management, but also to inform members of issues that affect the MHO and exchange information among members. Thus, these bodies allow private information – in the hands of management and individual members – to become public information. One vital piece of information exchanged is about members abusing the system. To the extent that every member of the MHO is co-responsible of the success of the institution, there are strong incentives for all good behaving members to keep control over those displaying aberrant behaviour. Further, should the MHO come close to failure, a general assembly meeting will have to decide on the future of the MHO and the actions that must be taken, including exceptional premiums, reduced coverage, disciplining aberrant members or other mechanisms, to insure the continuity of services, or to shut it down. None of this was necessary in the MHOs visited. During the visit to Cinzana, every member of the Board of Directors was aware of cases of aberrant members, how that information had become public, and was ready to note the pressure exercised by the body and other members on those individuals.

Adverse Selection

As noted in the previous paragraph, MHO use what is known as community rating – i.e. a common premium that redistributes the risk within the community making healthy and prudent people pay for the less healthy or the imprudent. In voluntary insurance markets, community rating increases likelihood of adverse selection and creates the so-called "death spiral" instability, with healthy people opting out. There are three basic mechanisms employed by the Mali movement of MHOs to control adverse selection:

i) the use of waiting periods,
ii) the organization of MHOs based on groups that exist for purposes other health insurance, and
iii) encouraging affiliation of entire families.

Waiting periods: These typically range between 3-6 months. Members who fall in arrears with the payment of the premiums in excess of a certain period (e.g. 2-3 months) must re-register and are never readmitted with immediate access to health insurance coverage. A waiting period of six month applies to the entire MHO in the case of newly created associations.

Use of natural grouping criteria: With respect to the second mechanism to control adverse selection, the groups are often based on a specific territory – mostly in rural areas – an employer (e.g. the Telecommunications MHO), a profession, or another social group that is easily identifiable. In the case of the MHO of *Sikasso*, the group is composed of all individuals attached to a farm.

Affiliation of families: The third mechanism, affiliating entire families, is strongly encouraged but not mandatory. In addition, particularly in rural communities, members that affiliate only sick members of the family are likely to be spotted by other members, and social pressure will probably ensue.

While waiting periods are used invariably, the second mechanism cannot always be employed. In the case of the UTM, for example, the urban "professional" MHOs are an

amorphous group with no particular "bond." However, in all cases members are encouraged to affiliate the entire family.

There are special situations. In the case of the Cinzana MHO, family membership is, of course, encouraged but there can only be 15 family beneficiaries. This is to prevent extended families from affiliating as a single family with a single registration fee. That is, 15 family members can be on the same membership card. Above 15, a new card had to be registered independently (with a payment of US$4.50 as registration fee) to include the remaining family members. Premiums are, of course, a function of the number of beneficiaries in the family. Also in the case of Cinzana, each beneficiary will receive an individualized "service card" (*carte de prestation*) that must be presented with the membership card of the household head to have access rights to health care services covered by the MHO.

To these standard approaches, we can add the mechanisms that result from the mutual nature of the contract. In effect, in an investor (or third party) financed insurance scheme, policies issued are non-participating (risk is not shared with the insurer). This discourages low risk individuals – those with risk inferior to that implied in the premium – from participating in the insurance scheme, while encouraging the participation of high risk individuals – risk higher than the premium. A mutual offers what is known as a participating policy – the insured shares risk with the insurer. In a participating policy, the insured-member receives policy dividends (i.e. any payoff, be this a dividend, reduced premium or increased coverage), which encourage participation of lower risk members in the scheme.[29]

Fraud

Directors and executives of the MHOs insisted that fraud is practically non-existent. Every member is issued a standard card with a recent photo (this is the case for members that subscribe to the standard VMHI plan and some *à la carte* HI plans) and with the name of other beneficiaries in the family as evidence of coverage. Members and beneficiaries must present this document to the health centre to have access to health services. The health centre ensures that the documents are legal and that the member is not in arrears. For this purpose, the points-of-service to which the members of a MHO have rights, are provided with list of all members in good standing. At the end of the month, the point-of-service must submit a list of the persons to whom health services were given. At that moment, the secretary of the MHO will verify that all persons who claimed are indeed members in good standing. No payment will be issued for individuals that are not eligible or whose evidence of coverage is not in order. Thus it is the responsibility of the health service provider to verify eligibility and identity. The Cinzana MHO management described only one case of an individual who attempted, without success, to obtain services by presenting the membership card of his brother. The member to whom the evidence of coverage belonged was warned by the MHO afterwards. Hospital services are accessible only through referral by the local health centre and also require presentation of an evidence of coverage. Thus, fraud is also controlled at the hospital level.

[29] The results are more general than that. High risk individuals will tend to buy insurance through non-participating policies and low risk individuals through participating policies. The importance of this result is that the participative nature of the mutual contract encourages low risk individuals to acquire insurance from them, something that investor-owned insurance companies cannot do.

Members seem to have embraced discipline. We were told the following anecdote about another rural MHO: A member was asked by his brother (not a member) to lend him his membership card to treat a child. The member was ready to help his brother cover the expenses of treating the child, but not to lend him his membership card.

For MHOs that adopted the standard VMHI plan, essentially the same procedure of fraud control applies, with the difference being that it is not the UTM does the administrative work.

Cost Escalation

There are at least two reasons why cost escalation has not been a significant problem. First, the relatively short life of the movement and the relatively low level of inflation in Mali mean that MHOs have not suffered significant shocks in costs for health services. Secondly, the insurance plans specify the use of standards procedures and cover only generic drugs. The government of Mali has made an effort to keep the costs of these procedures and drugs in check.

Covariant Risk

Covariant risk is a major source of uncertainty in many of the rural communities served by MHOs. This is due to the high dependence on agricultural income and the nature-based uncertainties typically associated with rural areas. In recent years, two important sources of covariant risk have been locusts and droughts. This has a double effect; it worsens nutrition among the communities affected, thus inducing weaker health and simultaneously reduces their capacity to afford the premiums required for the health insurance schemes, which are quite unforgiving to arrears. Malaria is probably the largest source of covariant risk in specific pathologies that are be covered by MHOs.

4.8 Marketing

UTM has foreseen a budget of 25 million CFAF (US$48,000) for communications and extension. This budget is for network-wide activities. There are also specialized budgets for regional offices based on their own plans to expand the membership in the region. This budget is about 16 million CFAF (US$31,000). Finally, there is also the work – mostly not compensated – that MHOs perform in their own community to attract more members. The UTM has estimated that, for example, in Segou, the cost of adding one beneficiary to the system is about 2500 CFAF (US$4.80).

There is a large variety of activities that are included in this work. The typical “membership drive” proposed by the different regions may include activities such as:

1. neighbourhood visiting (door-to-door) campaigns;
2. campaigns designed to affiliate employees of an enterprise;
3. collaborations with NGOs to address a particular target population;
4. alliances with networks of savings and loans mutuals.

These local activities are backed up by a set of communication and advertising activities in the national media. The purpose of these advertising campaigns is to increase the awareness in the population about the existence and work of the movement of MHOs, UTM and the

health insurance plans they offer. This also facilitates the work of the regional offices and MHOs in local campaigns because the targeted individuals are able to confirm that what the local agent is offering is consistent with what is being announced in the media.

The techniques used for membership promotion campaigns vary depending upon the context. In the case of a MHO like Cinzana that operates in rural area, members and directors of the MHO employ a variety of means such as:

1. Door to door visits in villages – mostly in the night, when people are at home – within the health district.
2. "Work" public events that involve people coming together (e.g. baptisms, marriages, sport events, town meeting organized by local authorities). At this a speaker will present, or a team of members will systematically "work the room", going from person to person, talking about the work of the MHO.
3. The village contact persons employ all means available in their own villages to inform and sensitize people about the MHO.
4. Encourage the public media (radio, newspapers) to report about or to perform interviews with members of the MHO, that describe the activities of the association.

Work in urban areas is structured differently and depends on the clientele. In the region of Bamako, the UTM undertook three strategies:

1. *Enterprises.* In the case of enterprises, a number of techniques that go from the person-to-person contact "working" the employees of an enterprise, to promoting the MHO in general assemblies of the work place.
2. *Mutuals:* A number of mutual institutions do not yet offer health insurance. In these cases the UTM undertakes negotiation with its leadership to incorporate health insurance to the products offered.
3. *Suburban:* Door to door visits

To provide an idea of the success rate of each strategy, we include a table specifying new members/beneficiaries obtained from the 2003-membership campaign around Bamako. As the table suggests, the most profitable strategy is the one related to the expansion of membership in enterprise MHO.

Table 4.3 Results of membership drive by strategy in Bamako - 2003

Strategy	New Members	New Beneficiaries
Enterprises	1802	5174
Mutuals	82	268
Suburban	57	225
TOTAL	1941	5667

Also, the MHOs have just recently engaged a marketing consultant who was in the process of preparing a marketing plan to increase the efficiency of recruitment efforts. The MHOs are not allowed (Art 9 of the *Decree 96-137 On the Model Statute for Mutual Associations, Unions and Federations of Mutual Associations)* to employ commissioned agents.

Effectiveness

While these expenses are, from a narrow point of view, attributable to marketing, their effect is not simply the sales of a product but, more importantly, the creation of MHOs, that are, in themselves, new selling points and mechanisms that empower the population to assume control of an important source of risk. These expenses generate a qualitative change in the social organization of communities.

An active and vigorous campaign appears to be important. The growth of members who bought the "standard VMHI" plan slowed down between 2004 and 2005 (see Table 5.1). This coincides with a slow down in communications and advertisement.

Among the activities designed to promote membership, the most effective is the simple approach of "door to door" promotion. These "doors" may be homes, schools or enterprises, but in every case, the personal contact with the target population yields the best results. The second most effective technique is the work with strategic partners including: networks of savings and loans mutuals,[30] enterprises, NGOs, etc. These partners have access to a population to which the information about the health insurance plans can be transmitted at a relatively low cost. The UTM has, in recent times, increased these types of partnerships. In particular, contacts and initial discussions have been held with the *Réseau Nyèsigiso*. This represents a challenge because it implies that the UTM must find institutional mechanisms to deliver insurance services and ensure the provision of health services for a national network of financial cooperatives, which is something that is beyond its current institutional and administrative capacities.

4.9 Customer Satisfaction

The key reason for non-renewal is lack of sufficient income to pay premiums, particularly during events that affect the local economy (e.g. lack of rainfall, low prices). While the opportunism of members is not totally discounted, i.e. members stop paying after benefiting from covered health services, according to most local players, this is not a significant factor.

Member satisfaction is generally high, although difficulties accessing services provided by the health centres may tarnish this image. As noted in Section 4.1, the partnership with the health centres is one that has not always been easy and one that still represents a major challenge for the UTM and the individual MHOs, and one over which they have very little control beyond engaging in agreements and supervising enforcement. One of the most frequently heard complaints among members of MHOs is about the service they obtain from the points-of-service. This tends to be particularly serious early in the life of the MHO – unless the health centre was itself involved in the process of creating the MHO – when the staff of the health centre may not yet be fully aware of the MHO and the agreements that exist with it. If the services provided by the point-of-service do not meet expectations, members may blame the MHO. It is not always clear to members that the MHOs and the health centres are two separate and unrelated entities.

[30] This includes the *Réseau des caisses d'épargne et de crédit Nyèsigiso* and the *Réseau Kafo Jiginew (Fédération des caisses mutuelles d'épargne et de crédit de la zone Mali Sud).*

5. Results

5.1 Management Information Systems

Due to the presence of the two plans, the standard VMHI and the *à la carte* HI, there are a different levels of information collection. The *à la carte* HI plan is managed by the MHO that offers it. Thus, the information is held locally, with only statistics transferred to the UTM. On the other hand, management of the standard VMHI plan is centralized at the UTM, so all information is managed by the UTM. This includes all accounting and statistical data that describe the evolution of the plan and the MHOs that offer it, which allows the UTM to assess the efficiency of the entire system. These management information systems are fully computerized with modules that allow system-level tracking of the regional offices.

5.2 Financial Results

Profitability and Viability of each Product Offered

Due to the presence of the two plans, financial management is at two speeds. The MHOs that offer the *à la carte* HI plan must, by definition, be self sufficient and sustainable. Their cost structure is very simple with at most a part time employee that takes care of bookkeeping. In the case of Cinzana, all work was performed by volunteers. Thus, expenses are practically limited to claims (health services), UTM affiliation fees and some transaction costs. Health services cover the bulk of expenses facing the individual MHOs. Except small variations, these MHOs are self-sufficient and sustainable. If deficits occur, they must be corrected by the MHO by adjusting premiums or services. That is, no long-term deficit is possible at this level, but short terms deficits may be covered with reserves. There is, however, an implicit subsidy in the form of services offered by the apex that are not fully compensated by the UTM affiliation fees. Design of products, negotiation and contracting with health providers and controlling performance by health providers – all major inputs into the process of generating the services other than claims itself – are covered by the UTM.

To provide an idea of the financial situation of a typical MHO, the financial report of one that offers a *à la carte* HI plan is extracted. The MHO was chosen randomly. In this case the MHO is Kourouma, which closed its year with a total of 136 (899) members (beneficiaries), up from 63 (474) at the end of 2002. The Income Statement and Balance sheet of the MHO are as follows:

Table 5.1 Income Statement of the MHO Kourouma (1000 CFAF)

Expenses		Incomes	
Item	**Amount**	**Item**	**Amount**
Claims	1176	Registration Fees	110
Functioning Exp.	180	Premiums	1609
Surplus	678	Surplus 2002	315
TOTAL	**2034**	**TOTAL**	**2034**

Table 5.2 Balance Sheet of the MHO Kourouma (1000 CFAF)

Assets		Liabilities and Net Worth	
Item	**Amount**	**Item**	**Amount**
Bank (Kafo)	673	Reserves	819
Bank (Other)	140		
Cash	6		
TOTAL	**819**	**TOTAL**	**819**

The VMHI is run differently. The MHO transfers the premiums income to the UTM, which manages the process from there on. For reporting purposes, the administration of the VMHI plan is viewed as a separate cost center. If costs remain within the estimates forecasted in the feasibility study, the plan is projected to break-even at 50,000 beneficiaries. Currently there are approximately 22,000 beneficiaries. As of this moment, the administrative charges attached to premiums cover about 65% of real costs of administering the VMHI plan. However, the proportion of premiums designed to cover risks (expenses in health services) presents a surplus. This is also the case for most MHOs offering the *à la carte* plan. In the table below, the evolution of premiums collected and disbursements made in health services for the years 2002-2004 and the evolution of beneficiaries affiliated to the standard VMHI plan at the closing of each year are presented.

Table 5.3 Evolution of Premiums, Disbursement (CFAF) and Active Beneficiaries (#) for the Standard VMHI Plan, 2002-2004

		2002	2003	2004
Bamako	Premiums	20 038 134	26 652 266	45 530 247
	Disbursements	5 015 753	14 118 030	12 483 583
Kayes	Premiums	4 535 050	6 621 680	6 278 870
	Disbursements	819 947	2 090 766	3 531 922
Sikasso	Premiums	767 120	3 060 190	5 276 020
	Disbursements	156 555	1 969 270	3 486 645
Ségou	Premiums		2 780 890	3 424 880
	Disbursements		317 205	1 129 975
Active Beneficiaries (all regions)	Men	3 689	7 264	9 096
	Women	3 833	7 338	9 590

Note: *Data for July 2005. Disbursements include only payments to serviced providers (i.e. excludes administrative expenses of the UTM)

Through its national and (three) regional offices, the UTM has to:

- support the operations of the MHOs operating *à la carte* plans;
- perform all administrative and support work for MHOs that offer the standard VMHI plan;
- promote new MHOs,
- keep track of the evolution of the system and
- represent the movement before the government

In fulfilling these responsibilities, it operates at a deficit, both globally and specifically with respect to the administration of the VMHI plan. Multiple sources of funding compensate for the deficit, but the bulk is covered by the *Mutualité Francaise* and on a smaller scale, by

Belgian funding and government funding under the *Programme de développement Sanitaire et Social* (PRODESS).

Table 5.2 Key Results (CFAF)

	2005	2004	2003
Net income (net of donor contributions)	88 219 000	64 4871 00	87 320 000
Total premiums (value)	67 779 640	60 510 017	39 115 026
Growth in premium value	12%	55%	
Administrative costs / premiums (19%)	12 878 132	11 496 903	7 431 855
Reinsurance / Premiums (1%)	677 796	605 100	391150
Reserves added for the period / Premiums (6%)	4 066 776	3 630 600	2 346 900

It was very difficult to obtain a clear picture of the finances of the UTM. The numbers given above are indicative, but do not allow for an assessment of the true financial results. One thing is clear – as of this date, the UTM is not covering all of its costs, but it should not be expected to do so anyway. Its promotional functions are too important, and the standard VMHI plan is at about 50% of its projected break-even point. Further, this product's growth has been less than expected. As of this point, it is nearly impossible to predict when the system – the combination of the VMHI and the *à la carte* HI plans – will become sustainable.

To provide an overview of the growth in membership and renewal rates, Table 5.3 provides the number of members, the beneficiaries and the drop-outs of the standard VMHI plan in each year. The last column presents dropouts as percentage of beneficiaries. The table presents a very clear trend of increasing dropouts in absolute numbers, but also as a percentage of total beneficiaries. While the first is to be expected, the second suggests a pattern that could be troubling.

Table 5.3 VMHI Membership

Year	Category	Total	Dropout %
2000	Members	745	
	Beneficiaries	2099	
	Dropouts	28	1.33%
2001	Members	1284	
	Beneficiaries	3593	
	Dropouts	101	2.81%
2002	Members	2708	
	Beneficiaries	8616	
	Dropouts	294	3.41%
2003	Members	5024	
	Beneficiaries	15499	
	Dropouts	769	4.96%
2004	Members	6507	
	Beneficiaries	19285	
	Dropouts	1396	7.24%
2005	Members	8183	
	Beneficiaries	24013	
	Dropouts	2353	9.80%

5.3 Reserves

MHOs have the obligation of accumulating 30% of operating surpluses as "technical reserves". Reserves resulting from operating "surpluses" remain in the ownership of the individual MHOs, but are not held individually by each MHO (both the "technical reserves" and the remaining 70%). Local general assembles decide about the use of these reserves. Yet, risks are pooled (*mutualized*) for the entire system by consolidating reserves, and they share equally all investments made by the UTM on behalf of the system. These reserves are kept in a bank account. However, it is important to note that these reserves are relatively small and their value as a "source of income" is quite marginal. This is due to the mutual nature of the insurance scheme that relies only marginally on equity and reserves (see Box 5.1).

Box 5.1 Mutual insurance: "pay as you go"

In contrast to the investor-owned insurance company that must keep sufficient actuarial reserves and equity to meet all its liabilities, in many mutual institutions that requirement is relaxed. Mutual insurance is often based on a "pay as you go" approach. It is not the technical reserves and third party equity capital that insures that liabilities will be met, but the solidarity of the members who retain a residual responsibility to cover losses ("the reserves in the pocket of the members").

The distinction is often made between mutuals with premiums and assessable policies and mutuals with premium and non-assessable policies. In the latter, policyholders receive dividends but are not levied with additional assessments for losses. Not surprisingly, regulators will require higher levels of capital and reserves for the latter. Mali's MHOs are among the former. A third form, without premium and assessment policies – also called post-paid – was common in the past, but is nearly extinct today.

Insurance specialists often argue that combining policy and equity claims in a single package (the mutual insurance contract) is a more efficient arrangement for risks that are not easily diversified. For those risks, a "third party" capital requirement and reserves would be too high and too costly. The mutual contract allocates residual risk to the policyholders – which is quite different from a pre-determined deductible – thus reducing the cost of the insurance, although the policyholder risks post event assessments. This is also one reason why mutual insurance tends to be cheaper and more common among low-income people. Pay-as-you-go schemes have differing levels of success. International experiences suggest that they work better for "casualty" insurance – like health – than for whole life insurance, due to the typical aging of population and increasing death rates as the scheme ages.

Interestingly, MHOs have, in general, not made use of reserves resulting from operating surpluses – even the non-technical reserves – to cover losses in later years. Generally, MHOs keep a tight control over disbursements and avoid making operating losses. As a consequence, the tendency has been towards a small but steady accumulation of technical and non-technical reserves.

Since the program is in its early stages, it is difficult to assess how smoothly this will work in the long-run. Mutual insurance plans display a typical upward trend in claims as the scheme ages and matures. At that point, adjustments may become necessary. However, the UTM seems to be well equipped in terms of technical and organizational means to adapt and introduce the changes needed to keep the system solvent. For the time being, the UTM is still some years away from such situations.

5.4 Impact on social protection policy

The evolution in membership and the technical expertise it has developed in management of voluntary mutual health insurance make the UTM a key partner of any program or activity related to social insurance in Mali. As a result of an agreement with the Ministry of Health and the Ministry of Social Development, Solidarity and the Aged, it is an active part of the National Program of Social and Sanitary Development of Mali. As such, it is a full member in all activities related to the management of this program.

The activities of the UTM have contributed to increasing social protection in Mali, particularly in health insurance. Mali does not have a mandatory regime of health insurance that covers the population at large. Now, MHOs are operating in rural and urban areas and cover about 40,000 beneficiaries.

Further, the UTM is an active advocate for the improvement of social protection and of health care services in Mali. The UTM has been at the origin of a letter that the Ministry of Health sent to medical staff throughout Mali about respecting their reticence to prescribe generic drugs. It is continuous interlocutor for health issues and innovation concerning the informal sector and has excellent relations with the government and their agencies.

6. Product Development

6.1 Product Concept

At the moment the product was developed, there was no competition. No other insurer offered health insurance to the population served by the UTM, the workers in the informal economy. Thus, competition was not an aspect to worry about in the design of the product. The focus was on offering a product that would address as many of the possible needs of the target group. Over the years the UTM, assisted by the MF, has developed a relatively standardized approach to developing health insurance plans. In the case of the *à la carte* HI plans, mostly offered by rural MHOs, the attention is on the population meeting the criteria of the MHOs. To develop the standard VMHI plan, a more regional approach was employed, covering most of the important urban areas in the southern portion of Mali (up to Mopti, along the Niger river). The basic approach used by the UTM is the following:

1. Identify health services available to the target population in the point-of-services;
2. Identify the cost of the health services offered and the difficulties of the population face in financing these costs;
3. Assess the level of development of the medical infrastructure and human resources available in the point-of-service;
4. Through *focus groups*, assess the needs and preferences of the target population in terms of what should be included in the plan. In these focus groups, the characteristics of the potential member are also identified, such as:
    a. Did potential members save in the past to cover sickness eventualities and if so how much did they save?
    b. How much would they be willing to put aside to cover those eventualities?
    c. What is the structure of their families and how many members do families have?
5. Once the main needs and priorities expressed by the target populations were established, i.e. the services that would be included in the plan, with assistance of the MF, actuarial studies were performed to assess the expected outflows given the pathologies characteristic in the population and services available in the health service centres and hospitals.
6. In the original development of the standard VMHI plan, several alternatives were considered and about five were proposed. Very early on, the focus groups opposed the alternative of including only specific pathologies due to operational difficulties of having to discriminate whether members were covered or not based on admissible pathologies. Thus, the decision was taken that whatever the plan, it would have to cover all pathologies that are treatable in the health centres. This forced the UTM/MF team to assess the cost of covering the entire set of pathologies present in the target population. The five plans proposed varied mostly on the level of co-payment (*ticket modérateur*) for different services.

7. The final choice of plan was again taken to the *focus groups*, which had to analyze and propose one of the plans.

For the standard VMHI plan, this process allowed the UTM/MF team to arrive at the conclusion that basic health (*soins ambulatories*) and hospitalization (*soins hospitaliers*) were the two key components of a plan that would best meet the needs of the target population. These two components were separated, allowing members to choose either or both. The final choice of the focus groups, based on what was possible within budgets, was the following:

1. Basic health (*soins ambulatoirs*) at 210 CFAF (US$0.41) per month per person for coverage of 60% of all pathologies.
2. Hospitalization (*soins hospitaliers*) at 270 CFAF (US$0.52) per month per person for coverage of 70% for hospital charges.
3. The Combined (*combine*) at 440 CFAF (US$0.85) per month per person for both.[31]

In the meantime, members have wanted to include ophthalmology and dentistry. The analysis performed by the UTM/MF proposed an increase of 20 CFAF (US$0.04) to include these two services in the Combined plan, making it 460 CFAF (US$0.89) per month per person.

In the case of the *à la carte* HI plans, the approach is similar albeit reduced in scope. In the case of the MHOs visited (Cinzana and Kulikoro), the UTM, in addition to collecting the information previously described, mobilized the community and encouraged it to express its preferences and priorities. This analysis was part of the feasibility study performed to assess the viability of the association. Eventually the UTM presented the community with three options that reflected the expressed combinations of coverage (e.g. hospitalization, maternity, child) and co-payments and premiums (levels, timing, etc). After few additional adjustments, the community chose one of the alternatives. A similar process was followed in the case of the Kulikoro MHO, which had a somewhat different result because of the different economic realities and natures of the communities.

6.2 Pilot and Rollout

Given the detailed preparation of the plan involving focus groups of current and potential members, no pilot testing was performed.

The “standard VMHI” plan was launched in 2001 during General Assembly of the UTM. The Minister of Health, other representatives of the government, the private sector, trade unions and other figures of Mali’s society attended the assembly. Interestingly, representatives of the insurance sector were also present, although not invited, and were curious about the health insurance plan, which is sometimes more comprehensive and cheaper than those available in the private sector…. at a very low price.

[31] Compare to the Millennium Development Goal proposed poverty line of $1.08 per day (based on a 1993 UN estimate adjusted for purchasing power). That is, on a monthly basis, for a person right on the poverty line, health insurance covered by the “standard VMHI” plan would represent a 4% of income.

7. Conclusions

7.1 Significant Plans

Its main products, the standardized and customized plans, are being expanded and no adjustments are planned. The most important innovation the UTM is planning is the creation of a *Reinsurance Schema* that would allow MHOs to transfer some of the risk to a network-wide risk pool. The exact characteristics of the reinsurance plan and whether the risk will be borne internally by the reinsurance pool (likely), or transferred to an external reinsurance (unlikely), are still to be decided. The community will then decide whether they will adopt the standardized plan – somewhat more costly but with all the advantages of delegating the management of the product to the UTM – or a *à la carte* plan.

The UTM is not working in the development of new products per se. However, every time a new MHO is created, the UTM assists the MHO in the development of a customized plan for the local community.

7.2 Lessons Learned

Major Breakthroughs

1. ***The network structure:*** The UTM has succeeded in developing, more than any other movement of MHOs in West Africa, a network structure that serves its members well. It has taken over most of the tasks that require advanced technical expertise, created economies of scale, and controls for some risks that result from the interaction between MHOs and the health service providers, the government, and other market participants.
2. ***The standard product.*** While there is considerable criticism for this product in the West African community, the experience is useful and interesting. There are important trade-offs in such a product. The product is less adapted to the particularities of each MHO. At the same time, it reduces the administrative load for the MHO since the UTM manages the administration, allowing individual MHOs to focus on what they can do best: expand membership, collect premiums, control adverse selection and moral hazard, manage the link between the local community and the health service providers (health centres and regional hospitals). Whether the plan will become the dominant product offered by the Malian network of MHOs is an open question, but it is an important experiment in standardization based on the principle of mutuality and could have important repercussions elsewhere. The adoption of the plan has increased steadily – no doubt helped by the marketing and pressure of the UTM – and MHOs do not seem to be reverting to customized plans, which would have signalled that MHOs' members or leaders were dissatisfied.
3. ***The locust plague:*** The passage of the locust swarms constituted a severe test for the MHOs in Mali. The effect was felt through a decrease in the regularity of premium collection in rural communities or in urban communities whose economy depended heavily on the surrounding agriculture. However, the movement of MHOs

survived. This event, although not the worst that could have occurred, was still an important one and demonstrated that the system is robust enough to face some important sources of covariant risk.

Major Challenges

The single most important challenge facing the movement is to reach sustainability. At the same time, there should be realism about this goal. Even movements with an indisputable historical success, such as the Bismarckian mutual "Kranken Kassen" in Germany or the French "Mutualité", each one today providing health insurance to the majority of the respective populations, were dependent on state subsidies for decades before the wealth of the population they served reached levels that allowed for sustainability. It would indeed be unreasonable to expect that *any* movement that provides this essential social service to large portions of the poorer population will reach sustainability in a unrealistically short time. Interestingly, as in the old movements of the past, the subsidy is not to cover risk, but to run the administrative structure required to make the system function successfully. *The distinction is not trivial. A subsidy for risk could become a huge incentive for moral hazard. A subsidy for the administration of the system, on the other hand, is neutral in terms of incentives, other than for agency costs by managers.* Whether the financing should come from the state, which is often unable to cope, or donor money, is less important.

Therefore, while it is reasonable to put pressure on the UTM to reach the break-even point and demonstrate that it can eventually become a sustainable movement, it is unreasonable to criticize it for not being sustainable after just a few years of operations.

7.3 Outstanding Questions and Conclusions

There are two approaches represented respectively by the UTM and the *Union de Thies* in Senegal. The more centralized (UTM) is more expensive and reduces the scope of autonomy for MHOs. However, it promises to reach a larger number of people more rapidly and may be subject to less variation in performance across MHOs. The second, exemplified by the *Union de Thies*, is less costly and allows for a larger level of independence in the operations of individual MHOs. However, its growth will be slower and there might be a high variance in the performance of individual MHOs. There is a need among actors to better understand the role played by integration bodies (apex) in addressing the risks faced by MHOs.

Annex

Interviews with individual MHO

	Kulikoro (Women's association)	**Segou (Professional)**	**Cinzana (farmers)**	**Post Office***
Type	Women's association (opening up to regional-A*ire de santé*)	Urban multi-professional	Farmers, regional - A*ire de santé*)	Post office employees (80% of employees)
Economic background	Women informal workers producing artisan soap out of seed residues of a cotton mill dump.	An employee of a mattress repairing workshop and an employee of a tiny haberdashery selling shop.	Peanut and other crop farmers.	Employees of a state enterprise.
Interviewee	Members of the executive committee.	Registered members (in separate interviews)	Members of the executive committee.	A registered member
Plan	Standard, option	Standard VMHI	"*à la carte*"	Standard VMHI
Risk	Malaria, respiratory diseases and diarrhoea.	No particular risk associated to this group. They are covered by the INPS plan but affiliated to the MHO to have access to to the standard plan	Economic: Locust, droughts, prices. Health: Malaria, respiratory diseases and diarrhoea.	No particular risk associated to this group. They are covered by the INPS plan but created the MHO to have access to to the standard VMHI plan offering superior coverage.
Premium collection	Monthly, collected directly by the MHO	Monthly, collected directly by the MHO. Funds transferred to the UTM	After harvest	Monthly Payroll deduction

*MHO of the post office