

MicroInsurance Centre Briefing Note # 5

Lessons from Health Care Financing Programmes in East Africa¹

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In East Africa, risk management tools for health care have traditionally centred on self-insurance and informal insurance based on kinship and other social relationships. Governments have implemented social protection mechanisms to assist in managing health risks with varying results. Frequently, these "tools" fall short of satisfying the financial burden of a household, and this can lead to financial crisis, chronic poor health, dangerous attempts at partial treatments, substandard care, and in too many cases, death.

Several health care financing products have been introduced to improve the ability of low-income households to manage their health risks.

The quality of these programs is variable. To learn more, a close review of seven of these programs was conducted. These include a mix of delivery models, and organisational structures, as well as some that lean more towards social protection and others highly profit oriented.

The seven institutions studied were:

- In Uganda: Microcare, CIDR, and the Kitovu Patient's Prepayment Scheme (KPPS);
- In Kenya: MediPlus and the Community Health Plan (CHeAP)
- In Tanzania: Poverty Africa (PoA) and the Community Health Fund (CHF)

Lessons

Although these institutions provide many important lessons, an overriding message, which was reiterated in different ways in each case, is that to develop an insurance business, an institution needs to have the expertise and risk management tools of an insurance company. Indeed, it tends to be best if they are a regulated insurer to take on health insurance risk.

Insurance companies are specialists in this complex business, have access to reserves and reinsurance, and are overseen by insurance supervisors. Non-insurers put their own businesses at significant risk, and they risk the capital and confidence of their clients. Non-insurers should identify a health insurance partner to work with in such endeavours.

The lessons presented below reinforce this conclusion, and offer some guidance for those who decide on absorbing some or all of the insurance risks themselves.

Management and Governance

- ✓ To make microinsurance programs successful, management capacity in insurance is necessary.
- ✓ Because microinsurance is a complex business and non-insurer management and staff tend to have weak capacity in microinsurance company management, it is important to strengthen boards through education and member selection.

Microinsurance Products

- ✓ Follow a systematic product development process when developing these products. CHaP tried to roll out without any systematic product development process. When they realised the severe problems they were heading for, they stopped the programme and re-evaluated. Without this, the institution likely would have been bankrupted, and its parent's reputation destroyed.
- ✓ Emergency loans with disbursements made directly to the health care facility can be appropriate and easier to manage than insurance. CIDR's community-based groups had the option of choosing insurance or emergency credit. All groups took insurance in the first year. By the third year, every group had switched to emergency credit. Now, the manager notes, they operate substantially like an MFI.

Operations and Accounting

- ✓ Pricing of microinsurance products must improve. Microinsurers must begin using professionally derived premiums. All but one in the group, have had serious problems underpricing their products. This depletes premiums almost immediately, leading to a vicious cycle of premium increases, reduced growth and renewals, increasingly slower payments to providers, service refusals, premium increases. Price correctly the first time, even if it is conservative. It is always easier to reduce the premium than to increase it.

- ✓ Underwriting needs to be simple and efficient for the low-income market. CHEaP copied their form from an insurance company. It is difficult for clients to use, and management does not use the provided information for decision-making.
- ✓ Risk management policies must be followed rigorously. Microcare and KPPS both used a 60% rule (to cover any people from a group, at least 60% must pay premiums). When marketing was difficult, this rule was abandoned. Very quickly, they experienced extremely high utilisation from members of these groups because only the sick joined. Strong sales policies, and sanctions to enforce them, are important components of insurance risk management.
- ✓ Claims should be paid directly to the provider rather than as a client reimbursement. This promotes earlier treatment (and thus a lower cost) since the patient does not have to find money before obtaining treatment. Hospitals also preferred this because as one administrator from Kibule Hospital noted “this plan gets more people to come here, and we are assured of payment.”

Marketing

- ✓ Marketing management is a critical ingredient in creating an effective commissioned sales team. One institution’s manager would send the sales team to make initial sales but did not coordinate the renewals. Some people’s policies lapsed simply because no one asked them to renew. MediPlus’s well-trained, commissioned sales force quickly accumulated over 60,000 covered individuals.
- ✓ Microinsurance sales require a strong component of market education. Low-income people usually either do not know or understand insurance, or they have a negative attitude. People need to clearly understand what they are purchasing if there is any hope of renewals. CIDR spends significant time in the community explaining insurance even before any selling.
- ✓ Access to convenient high quality providers with flexibility of choice for the client is necessary. KPPS had difficulty because people did not want to come all the way from town to a hospital where they were treated rudely. MediPlus developed a large network of providers to offer choice to clients and create competition.

Risk Management

- ✓ The closer your staff members are to the health care facility, the easier it is to manage moral hazard and fraud controls. Microcare manages their own check-in desks in the reception area of their covered hospitals. They note that this and other controls help them reduce costs by 30% costs allowing for a reduced premium, without sacrificing profitability.
- ✓ Any institution that carries significant insurance risk must be regulated, well capitalised, and willing and able to lose some money while the product is growing. This protects clients and institutions. None of these programmes were adequately capitalised except CHF where members paid premiums, and government paid the expenses.

Provider/Insurer/Intermediary Relations

- ✓ MFIs have been weak partners in microinsurance. MFI commitment has often been limited to opening their doors to the health care financing marketers. This is not enough to generate significant sales or efficiencies. MFI staff should be actively involved in the sales, and management should consider providing loans, like one MFI in Uganda, or special savings vehicles to help people pay the premiums.
- ✓ Construct formal agreements with partners so that everyone is clear about their role.
- ✓ Conduct due diligence exercises on partners. There were few examples of any due diligence having been done before relationships formally started. At least one hospital required advance payments of approximately US\$600. MediPlus ultimately went bankrupt leaving paid-up members without any access to care from the premiums they had paid.

Preventive Health

- ✓ Coordinate external health information outreach programmes with microinsurance. KPPS and CHEaP had related partners providing preventive health care education and services, but neither had a linkage with their health care financing arm. MediPlus offered reduced cost fitness centre membership.

These institutions are blazing a trail in a new realm. The lessons they have learned can help others in developing better, more efficient, and more effective means to achieving the lofty goal of providing affordable, high-quality health care to low-income families.

¹ This note is based on a synthesis paper by Michael J. McCord and Sylvia Osinde. “Reducing Vulnerability: The Supply of Health Microinsurance in East Africa.” *MicroSave-Africa* 2003. This note, and the individual case studies it synthesises, is available at www.microinsurancecentre.org, as is the companion paper on demand – “Reducing Vulnerability: the Demand for Microinsurance” by Monique Cohen and Jennefer Sebstad (*MicroSave-Africa*, 2003).