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Building a Bridge Between MFIs and the Health Sector

Innovative Health Care Financing Scheme for the Low-Income Community

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K-Rep/AAR's Health Care Financing Scheme

The Health Care Financing (HCF) Project brings together a diverse consortium comprised of AAR Health Services, AAR Credit, K-Rep Bank and K-Rep Development Agency to develop and test an innovative, private sector-driven, commercially viable and replicable health financing scheme to reach low-income groups. Through the project and its consortium partners, a range of health care financing products have been developed and are being pilot tested. These products will contribute towards quality, accessible and affordable health care financing services for the low-income groups. This is achieved through the establishment of franchised health centres in the low-income areas of Nairobi city that offer both fee-for-service and also provide health care to families covered by the AAR Afya health care financing plans.

AAR Franchised Health Centres: AAR successfully established three urban-based franchise health centres in Nairobi - specifically in Kawangware, Buruburu and Kasarani areas in the close proximity of low-income community. These franchised health centres are crucial for the marketing of Afya products because these serve as "home clinics" for the Afya members. Between January 2003 and March 2005 these three franchised health care centre have received a total of around 40,000 patient visits (from both fee-for-service and Afya members) and currently receive an average of around 1,000 patient visits per clinic per month.

"Afya Card" Products: The product concepts were the result of extensive market research conducted by KDA. Coverage components and pricing have been determined through actuaries who have been working with the HCF consortium since February 2002. The pilot test ran from January 2003 to April 2004 and was used to assess options for the product. However, the process of fine-tuning the product still continues as the project's understanding of customers' needs and health-seeking behaviour grows through the pilot test/rollout process. Three products are currently under rollout:

- Afya 1: An in-patient only cover
- Afya 2: Comprehensive in and out-patient cover
- Afya Maisha: An in-patient only cover targeted for the corporate members

The intention with these product options is to create a range of opportunities to satisfy the needs and abilities of the target market of low income, self and otherwise employed and their families.

The target clientele for the Afya card products are as follows:

- K-Rep group (in particular K-Rep Bank) clients, who are typically drawn from the informal "*jua kali* " sector;
- Support staff of the existent pool of AAR corporate members - since employers of low-income workers have also expressed significant demand for a low-end health care financing product. This has proved to be a significant source of clients from the target market; and
- Other small-scale businesses such as taxi associations, small hotels, security companies, petrol stations and supermarkets, formal and informal organisations and individual families.

Afya Loan: "Afya Loan" is a flexible credit facility offered by the K-Rep Bank and AAR Credit to low-income clients to allow them to finance their annual membership fees for the Afya products. The size of the loan amount depends on the family size and is the equivalent to the Afya Card annual membership fees. The Afya Loan provides credit for a maximum of 10 months credit – and the clients must put a down payment of 1 month premium at the beginning of the loan. The loan repayment is on weekly or monthly basis, as this model has worked for the business loans in many microfinance institutions. Around 40% of all clients are using the Afya Loan to finance their premiums.

Lessons Learned

During the product development phases and the pilot test period, the project has faced several challenges that have resulted in its slow growth and along the way it has learned important lessons. These are broadly as follows:

1. **A New Concept:** Health care financing for the low-income community is a new concept in Kenya. As a result, selling the concept to different relevant parties i.e. actuaries, insurers, secondary care providers (hospitals), health service providers - even clients was very challenging and time consuming.

2. **Actuarial Analysis:** There was no data available for the low-income peoples' health seeking behaviour and use of medical facilities. The actuaries had to depend on HCF's Market Research report and few months' data from the franchised health centres, which was not enough for actuarial analysis. Ultimately, the Kenyan actuaries had to contact South African counterparts because they had some experience of the low-income market. After seven months struggle, HCF finally received actuarial figures.

3. **Insuring the Product:** When the product was ready for market, no insurers wanted to take the risk of underwriting this new, untouched and unknown market. The challenge was to get the insurers to understand the potential of the low-income market and to recognise the inputs from the actuaries and microinsurance consultants on product pricing. It required significant effort to demonstrate that the product represented a business opportunity for all parties through catering for the health care needs of low-income people; and thus get insurance for at least the in-patient portion of the Afya Card product.

4. **Health Financing Product Buy-in by the Senior Management:** To develop an appropriate product and implement a successful pilot test, it is very important to have full support from the senior management. A partnership model needs active and committed participation from all partners. The motivation of mid-level or junior staff member depends on signals they receive from the senior management. Lack of institutional will and cooperation sometimes hindered the achievement of sales targets.

5. **Establishing and Developing the Consortium:** The HCF Project worked hard to establish a collaborative working partnership between the consortium members. This is the first initiative in Kenya (and probably worldwide) to build a bridge between a health organisation (and its franchise outlets) and microfinance bank (and its research and development agency). There are significant institutional culture differences and objectives between these organisations, and these required careful, patient and diplomatic management. It also required constant mediation and negotiations between all the consortium partners.

6. **Political:** In January 2003, as the Afya Card was launched, the Health Minister and Ministry of Planning repeatedly promised to provide "free health care for all". These promises to the public had a huge impact among the low-income communities – Afya Card's market. People wanted to believe that soon they would receive free health care – and in the resulting uncertain environment, few wanted to participate in a

health financing scheme and commit themselves for a year. Nearly two and half years later, the Government of Kenya is still assessing how to deliver on this promise.

7. **Marketing Issues:** To date, the appropriate marketing of Afya Card remains one of the biggest challenges. The low-income market for health care financing products is brand new to all parties involved in the consortium. It has been difficult to achieve clarity and congruence of vision/effort on the marketing of the Afya Card amongst the consortium members. The project continues to test innovative ways to market Afya Card to the low-income community. One thing is clear: to sell the Afya products to microfinance clients the microfinance officers need to team up with the sales and marketing force of the health service providers so that they can handle all the objections and Frequently Asked Questions (FAQs) from the potential clients.

8. **Quantitative Targets and Incentives for the Sales and Marketing Staff:** It is important to provide quantitative targets to the sales staff in order to encourage improved performance, and to be able to assess their performance. Contests and rewards for sales performance were introduced during the pilot test, and these showed great potential for increasing sales. However, budgetary constraints among the consortium partners meant that this incentive scheme was not extended and tested further.

9. **Product Restrictions:** Under the Afya Card clients are tied into using specific "home clinic" franchised health care facilities, and to a maximum number of visits per year (for example a family of 5 is limited to 20 out-patient visits in a year). These restrictions are essential to keep the annual membership fees low. This has, however, caused some problems in take-up since the product is seen to be subject to too many restrictions. Work is underway to re-balance costs and restrictions while protecting the quality of the services provided.

10. **Balancing Services Offered and Price:** The project has faced a dilemma not uncommon in insurance – those who can afford the premium want access to higher-grade hospitals and those that are happy just to get access to the lower-grade hospitals often struggle to afford the annual membership fees. This remains a challenge, and the project continues to track and analyse the annual membership fees to claims ratios in order to try to respond to this.

11. **Marketing Constraints Due to Key Staff Turnover:** During the product development and pilot test period, on several occasions, the project had to cope with high staff turnover among all consortium partner organisations. When personnel left or were transferred, the positions were vacant for a while and then new incumbents were largely ineffective during their induction period - this also contributed towards the poor sales of the Afya products.

12. **Orientation and Refresher Training on Products at All Levels:** Health Insurance is complicated issue, thus before marketing the product, relevant staff needs thorough training to ensure that they understand the product, its fees and benefits schedule, inclusions and restrictions etc. The training is not only necessary for the direct sales and marketing staff, it also needs to encompass line managers, business development managers, microfinance officers, health service providers, as well as the customer service and public relations departments.

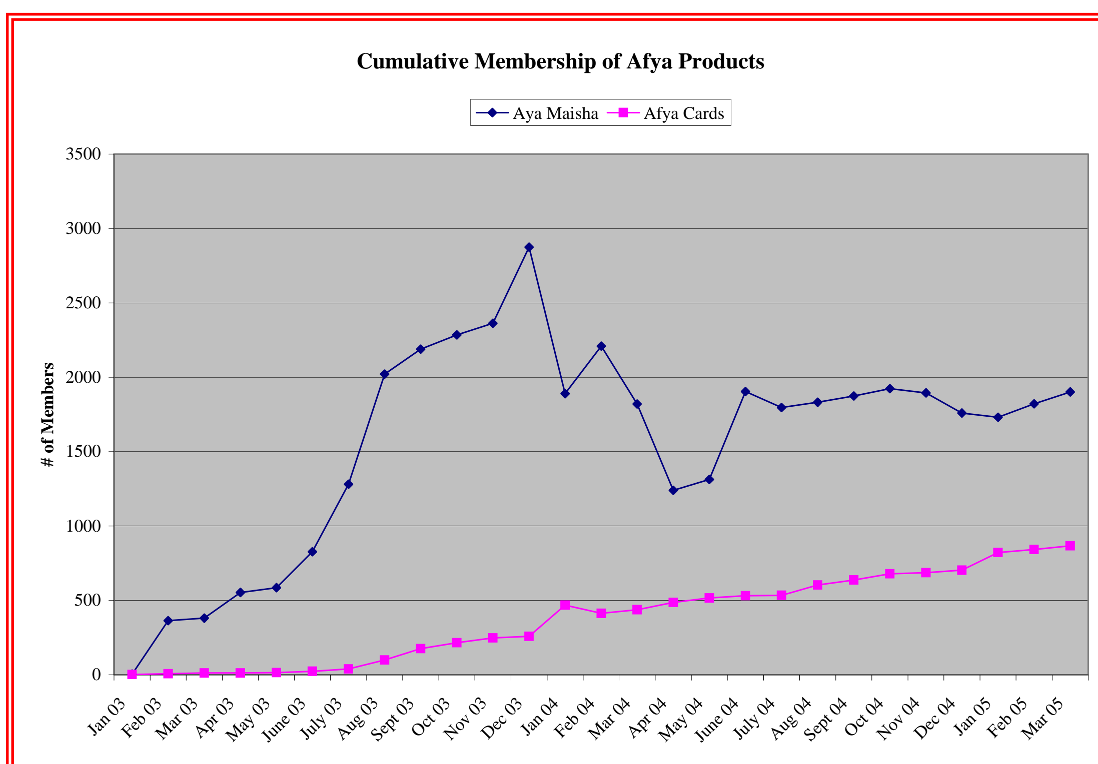
13. **Clients' Understanding of Health Financing Product:** It is clear the low-income people do not understand the health financing products or risk pooling adequately. This leads to poor sales of the product because potential clients are nervous to pay up-front for the health when they are not sick. Sensitising the community and convincing low-income clients to buy the health cover for themselves and

their families is not an easy job. It is important that training is provided to the clients from the start, even before the launch of the product.

14. **Tracking Systems:** While the pilot test started, the consortium members felt the urgent need to develop an effective financial tracking system to keep record of the sales of Afya products. In particular, a sound tracking system was needed for the Afya Card and for the Afya Loan. Launching a sound tracking system which can immediately capture and inter-relate (a) membership details; (b) financial data on premiums paid up front or through the loan product; and (c) claims and utilization, remains a challenge.

Successes

Despite these challenges, the results of the Afya products are promising, as shown in the graph below. The Afya Card products have shown a steady increase in take-up and while corporate renewal/lapses drive the fluctuations in the cumulative membership of Afya Maisha, it also shows an overall upward trend. This positive trend is now expected to accelerate after the media reported that the Kenyan government has announced that it is unable to afford the health-for-all (thorough the National Social Health Insurance Fund) as originally promised by the Minister of Health.



Overall, the findings from the project provide reassuring indications that the health care product(s) tailored for low-income groups do indeed have a huge market in Kenya. Indeed AAR is looking at replicating the product in Uganda and the re-insurer seems set to replicate the product in Tanzania, so it is clear that the commercial case has been broadly accepted by those involved. However, such products need a dedicated, active and focused marketing team, as well as broader based outlets (for example the Kenya Post Office Savings Bank has expressed interest in marketing the product), to achieve the target for marketing and sales.

It will take time to penetrate this market and gain understanding, trust and confidence from people. In addition, because health insurance is less tangible many people take a long time to understand the concept and decide to take up membership. Many potential/interested clients in the community are watching closely their peers who have enrolled. As a result, it is very important to build a good rapport with the current members, since they are likely to play the role of a catalyst or ambassador in their community ... and to drive the all-important word-of-mouth marketing.