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Microinsurance:
A Case Study Of An Example Of The Mutual Model Of Microinsurance Provision

UMASIDA

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6 December 2000

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Michael J. McCord

INTRODUCTION:

Most people experience financial stresses that are potentially disastrous. This is especially true for the poor in developing countries. Much microfinance activity, including that which incorporates savings programs, has been done in an effort to relieve some of these stresses and help people to secure, and even improve, the financial status of their families. As a result, many poor people in developing countries have experienced improved household incomes. They also see the benefits of saving money, as well as maintaining a healthy credit relationship, to protect themselves against future crises.

It has become clear that savings, though critical, only address relatively simple life cycle events and minor emergencies. The issues of health care financing, deaths, and property loss, for example, often require a greater level of support so that the involved family does not slide back down the slippery slope of poverty.

For this reason, there has been much discussion about the provision of insurance products to the poor in order to address the needs arising from such events. Indeed, several organizations have created programs to provide insurance products, utilizing any of four general models of insurance provision. These models include:

1. The Partner-Agent Model
2. The Full-service Model
3. The Mutual Model
4. The Provider Model

This series of case studies is designed to review some of the products of the more prominent organizations offering insurance products to the poor and to review their product development and implementation of these models. The UMASIDA case study provides an example of the Mutual Model.[1]

Objectives: This study reviews the Mutual Model of health care financing. It presents an understanding of the mechanisms and practicalities of the model, as well as the satisfaction level of the partners and the market. Benefits and problems are identified, thus aiding in the identification of further potential applications. Additionally, this paper reviews the process by which the product was developed, tested, and implemented to provide information on the process itself and to identify issues in the product cycle.

Methodology: The assessment of UMASIDA was conducted through a field visit during the period 2 – 7 July, 2000. The consultant conducted interviews and document reviews with all partners (UMASIDA and several of its local affiliated groups and the doctors they work with). Leonard Mutesasira from ***MicroSave*** conducted Participatory Rapid Appraisal (PRA) and focus group discussions with clients, former clients and non-clients.

Claims records, as well as accounting and other documentation where available, were reviewed to identify utilization and purchase rates. The PRA was conducted in order to gain an understanding of the perspective of the market.

[1] The author wishes to thank the management, staff, of UMASIDA, the management and members of the following community based organizations affiliated with UMASIDA – Mfavesco, Vifaa, Mbagala, Dasiko, and Keko , and the doctors and nurses of Tyma Clinic, Bilal ben Rabah Clinic, Mashuda Dispensery for their time and candor during the research of this case study. Special thanks to Janet Schenk McCord for her invaluable editing assistance. Most of the information reported in this paper derives from discussions with them and UMASIDA internal and public documents, which they kindly shared with the author.

I. Context:

I.A: Macroeconomic & Legal Environment

Table I.A.1: Tanzania Country Basics[2]
(1998 unless noted and US$ where relevant):

GDP (US$ Billions)	7.2
Population (millions)	32
Surface Area ('000 Km^2)	945
GDP/Capita (US$)	220
GDP Growth Rate (1997-8)	6.5%
GDP per Capita Rank (of 206)	194
Population per Km^2	36
Inflation (1999 est.)	8.8%
Exchange Rate (Tanzania Schillings per US$1)[3]	800
PPP GDP per Capita (1999 est.)	550
PPP GDP per Capita Rank (of 206 countries)	205
Infant Mortality (per 1000 live births) 1970/1998	129/85
Under Five Mortality (per thousand) 1970/1998	218/136
Maternal Mortality (per 100,000 live births)	530
Access to safe water (% of population) (1996)	49
Health Expenditure as % of GDP (public/private/total)	1.3 /NA/NA

I.B: Institutional Summary

UMASIDA is the **U**moja wa **Ma**tibabu kwa **S**eckta **I**siyo Rasmi **Da**r es Salaam (Dar es Salaam Association for Health Care Services in the Informal Sector). The ILO created the organization in November 1994 as one component of a larger ILO initiative, the Interdepartmental Project on the Urban Informal Sector. The Interdepartmental Project on the Urban Informal Sector was intended to demonstrate how to improve the quality of employment for the informal sector, particularly productivity, social protection and occupational safety and health, through enhanced access to resources and markets, collective actions, and regulatory reforms. This project has a number of components and works with cooperatives, labor groups and market groups.

The health-financing component of the Interdepartmental Project on the Urban Informal Sector was created in response to a dramatic shift in Tanzanian health care policy. In 1993, the Government of Tanzania recognized that it could no longer provide "free" health care to all citizens, and implemented cost sharing at government facilities and liberalization of the health care system to private clinics. A study conducted by the ILO and the Institute for Development Studies showed that the informal sector workforce was negatively impacted by these changes, and they sought to improve the situation of this market. A timeline of significant events in the creation and implementation of the UMASIDA project is presented in the table below.

[2] Data from 2000 World Development Indicators, World Bank, Washington, D.C. 2000. pp. 12, 16 and 92; and CIA – The World Factbook 2000 – Cambodia, http://www.odci.gov/cia/publications/factbook/geos/tz.html#top
[3] This exchange rate will be used in all calculations of current figures in this paper.

Table I.B.1: Timeline

Date:	Event:
November 1994	ILO/IDS report showed the need for improved health financing mechanisms for the poor
March 1995	ILO/IDS began discussions with five workers groups about different financing models to improve their access to health care. These groups had been previously trained by GTZ
August 1995	ILO/IDS helped groups compose executive committees to manage the logistics of the mutual type program that all the groups selected. Group chairpersons later make up the UMASIDA executive committee.
October 1995	Premium rates set (Tshs 600 per month per 6 family members) and agreed by groups
November 1995	Management attempted to open UMASIDA bank account but were rejected since they were not registered by the government. Began registration process.
December 1995	Personal account opened by UMASIDA director to act as UMASIDA account until UMASIDA is formally registered. Three signatories required.
March 1996	First contracts with providers and first care provision
September 1996	Program suspended by UMASIDA due to severe abuses
February 1997	Program restarted with control adjustments in place. Premium increased to Tshs 1,000 per month, significant controls implemented.
March 1997	UMASIDA registration with government completed
January 2000	Premium increased to Tshs 2,100 per month
May 2000	Premium increased to Tshs 3,000 per month for one group (others likely to follow)

Relevant Institutions:

The health financing component of the Interdepartmental Project on the Urban Informal Sector has three components: the UMASIDA apex organization, the Mutual Societies (all of which existed prior to the creation of UMASIDA), and the participating clinics.

Table I.B.2: Relevant Institutions

	UMASIDA	Community Based Groups	Clinics
Corporate Type:	NGO	Community groups	Private ownership
Legal Structure	NGO	Registered as Societies	Licensed with Ministry of Health
Core Products	Technical assistance and centralized accounting and oversight	General assistance and representation	Health Care provision
Start of operations	December 1995	Varies – all existed prior to UMASIDA	Varies after 1993
Number of Clients	6 groups	Approx. 5,000 total	>2000 each
Number of staff	2 (part time)	4 each (unpaid society executives)	NA

Although inspection of the groups and the UMASIDA books suggest that total insured members are approximately 300-400 with total insured of about 2000, UMASIDA management reports about 1,000 members and about 6,000 insured. Part of this discrepancy is one group in which all market members are considered members, yet only a few have access to the health care services. UMASIDA reports eight groups participating in the scheme but an examination of their books reflects only six groups with any balance (positive or negative) in the UMASIDA account.

I.C: Product Description

The ILO and IDS, in conversation with workers groups, developed the concept and basic components of the health financing scheme. UMASIDA is an apex organization that coordinates the management of the self-insuring Community Based Groups, and provides training and technical assistance. Community Based Groups become members of UMASIDA, and their members actually manage all aspects of the scheme. Each Community Based Group has the freedom to manage their group's health financing scheme according to the desires and abilities of the members and elected management. The components of the concept follow:

Table I.C.1: Product Description

	Health Insurance Program
Target Market (client type):	Cooperatives and Market groups
Target Market (geographic):	Dar es Salaam perimeters
Intended client benefits	✓ Improve health of clients and their families ✓ Improve financial stability of families ✓ Reduce time of searching for quality, affordable health care
Product coverage	In Private Clinics: ✓ Out-patient medical care
	In State Run Hospitals: ✓ In-patient medical care ✓ Surgical procedures ✓ Delivery ✓ X-rays ✓ Tooth extractions
	In both private clinics and state run hospitals: ✓ Medications ✓ Tests
Limitations	✓ Procedures beyond primary and emergency care must be performed at a state run hospital ✓ Drugs covered are generic and solely from essential drugs list. ✓ Clinics to provide only consultations, specific identified laboratory investigations, and medications from the essential drugs list. ✓ Serological tests only on approval of UMASIDA
Exclusions	✓ No exclusions stated
Eligibility Requirements (and renewal terms):	✓ Open to all accessible to the group's central location ✓ Renewal monthly ✓ Original two month waiting period (not enforced) ✓ Renewal after default with payment of arrears Members missing payments for more than three months are ejected
Pricing (premiums)	✓ Prices set by individual groups, most charge about US$2.50 per "family" per month ✓ Policy states coverage for two adult parents and four children. In practice, covers two adults, the man's parents, and all their children ✓ Policy states coverage over six people requires additional full "family" payment. No evidence of enforcement.
Pricing (co-payments)	✓ No co-payments charged ✓ State Hospital's co-payments or cost sharing due from the patient is covered by UMASIDA
Other:	✓ Members are issued an identity card for themselves and their families. In some cases, photos are also kept by the clinic for confirmation when sick cards (see below) are unavailable.

II. MARKET RESEARCH

II.A: Market Definition/Segmentation

As a component of the ILO Interdepartmental Project on the Urban Informal Sector, the target market was defined as the informal sector workforce. The first step was to identify the worker groups that would be part of this overall project and have the option of participating in the health financing scheme.

II.B: Market Research Process

The ILO/IDS team used a census conducted by GTZ (providing detailed data on associations in and around Dar es Salaam) to identify the target informal sector associations. The main criteria for initial discussions was a membership of greater than 300. Because the project itself was a research activity, associations selected were geographically separated and focused on different industries. Also, because this was a component of a larger project, market research was more generally focused on overall project goals, with limited focus on the specific market needs with regards to insurance. This made it particularly difficult to identify specific testing groups that were fully appropriate for testing an insurance product.

In refining their market research, the ILO/IDS team used several methods, including:

- focus group discussions and individual interviews with potential clients and their groups,
- focused discussions with local and sectoral opinion leaders, and
- review of existing documentation.

Once they met with the groups, key issues for continuation included:

- trust in the groups' leadership by the group members
- the ability to generate contributions from members, and
- their ability to provide services to their members.

The team concluded that eleven groups met the criteria.

ILO/IDS staff outlined several options for health insurance structures to the groups. Of the eleven, five groups agreed to participate and, after consideration, chose the mutual type where they would "own" the program. This is not surprising given the ILO focus on participatory entities, and the appearance was of a clearly supply-driven product. Thus, the results may be skewed due to high expectations of members that this would be donor financed, versus the chosen mutual structure that stresses self-reliance.

Six groups did not join the health financing scheme due to poor mobilization and a reluctance of their members to pay for an untested product.

In retrospect, UMASIDA management recognizes that there should have been greater effort in reviewing the literature relating to the implementation of this and other insurance provision models. This might have helped them to address in advance many of the problems that arose during implementation.

II.C: Competitive Analysis

No competitive analysis was done related to this product. The private health care system was just beginning to solidify and there were few non-traditional insurance type products serving any market in Tanzania. Some doctors had introduced capitation policies, and others offered very short-term credit. There was no competition for this product on the market when ILO/IDS started. Even now, there are few health insurance schemes in Tanzania, although there are some other mutual insurance programs also sponsored by ILO.

III. PRODUCT DESIGN

III.A: Prototype Development and Testing

The product was originally designed by UMASIDA and ILO/IDS is as follows:

Table III.A.1: Product Components

Terms, Conditions and Coverage:	Reasons:
Group selection	Groups were selected by UMASIDA based on participation in a broader scheme. The groups voted to join and members chose to join.
Members design the policy	With assistance from UMASIDA, member groups identified the coverage they wanted, and agreed to a price for the coverage. Generally, the coverage and the price were promoted by UMASIDA and members made small changes to the recommendations.
Combination of care through private clinics and public hospitals	Public hospitals are still heavily subsidized so any expensive treatment (secondary and tertiary care, as well as x-rays and other diagnostic tools) could be provided by them for a much lower cost, while basic primary care could be provided by the private clinics near the insured's workplace.
Secondary care reimbursed by UMASIDA if care was pre-approved by UMASIDA, and the group leadership.	This was an effort to contain costs and manage moral hazard.
Provide coverage to family members	Group members chose officially to cover two adults and four children with the premium.
Require two months of premiums before service is available	Allows for mitigation of adverse selection, and the creation of a reserve fund
Members would cover the costs of their scheme	Although there were initial and subsequent funds from ILO, the member groups are expected to cover their costs entirely and internally.
Management of day-to-day scheme activities by group management	In keeping with objective of the group owned scheme, executives were elected to manage the affairs of the scheme
Monthly premium payments to UMASIDA with internal premium payment as members choose[4]	Designed to limit administrative burden on UMASIDA, while promoting a payment system that fit the cash flow needs of the individual members.
Bill payment centralized at UMASIDA	Allows Dr Kiwara (the UMASIDA Director) to control medical charges and care from the clinics, and limits funds available to the group executives (mitigating the potential for fraud).
ID cards provided to all insured	To minimize fraud
No additional payments by clients at clinics	To facilitate use by members
Cover only medications from a list of essential drugs	To help control costs

In general, the initial plan was to work with five groups and then expand to five additional groups. Recognizing limited capacity, UMASIDA decided to limit the number of groups to these ten. Several of the groups have dropped out because of "bad" management, as UMASIDA reports. Funding was

[4] Note these payments are made in arrears to UMASIDA. Groups make premium payments for the month of service at the end of that month.

provided exclusively for the provision of research and mobilization during the first year ($5,000) and no funding was provided for further operations, although later funding was provided for the salary of the bookkeeper.

Based on initial discussions, UMASIDA planned to cover only primary care. However, members made it clear that workers often have needs that go beyond simple primary care, and so the coverage was expanded.

The mutual health financing concept was presented to the groups as flexible since it was a scheme they would "own," but there were very few minor alterations made by the groups to the basic package. Where group ownership did result in real self-determination was in the selection of the clinics and in the choice of leadership. The elected chairpersons from each group would then act as the board for UMASIDA.

Next, UMASIDA took the concept to the clinics that were chosen by the groups. With the group leaders, UMASIDA explained the program and helped the group leaders negotiate for a service discount (often 20-30%).

UMASIDA then trained the groups and the doctors (separately) on the system, and began collecting premiums.

There was no formal concept-testing phase, as UMASIDA skipped over testing altogether and the product went directly to a limited rollout.

Each component of the health financing relationship has its own objectives. The primary objectives of UMASIDA, the clinics, and the members are outlined below:

Table III.A.2: Primary Objectives

UMASIDA:	Community Based Groups:	Clinics:
Develop a replicable self-financing model for satisfying health care needs of informal sector workers in Tanzania	Improved health of members	Gain access to a stable additional patient pool, and lock them into service provision by the clinic
Create a structure that provides full program ownership to the users/members	Minimize health cost shocks to members	Reduce collection burden through the billing system
Demonstrate how to improve the quality of employment through enhanced access to resources		Improve profitability

III.B. Delivery Channels and Partnerships:

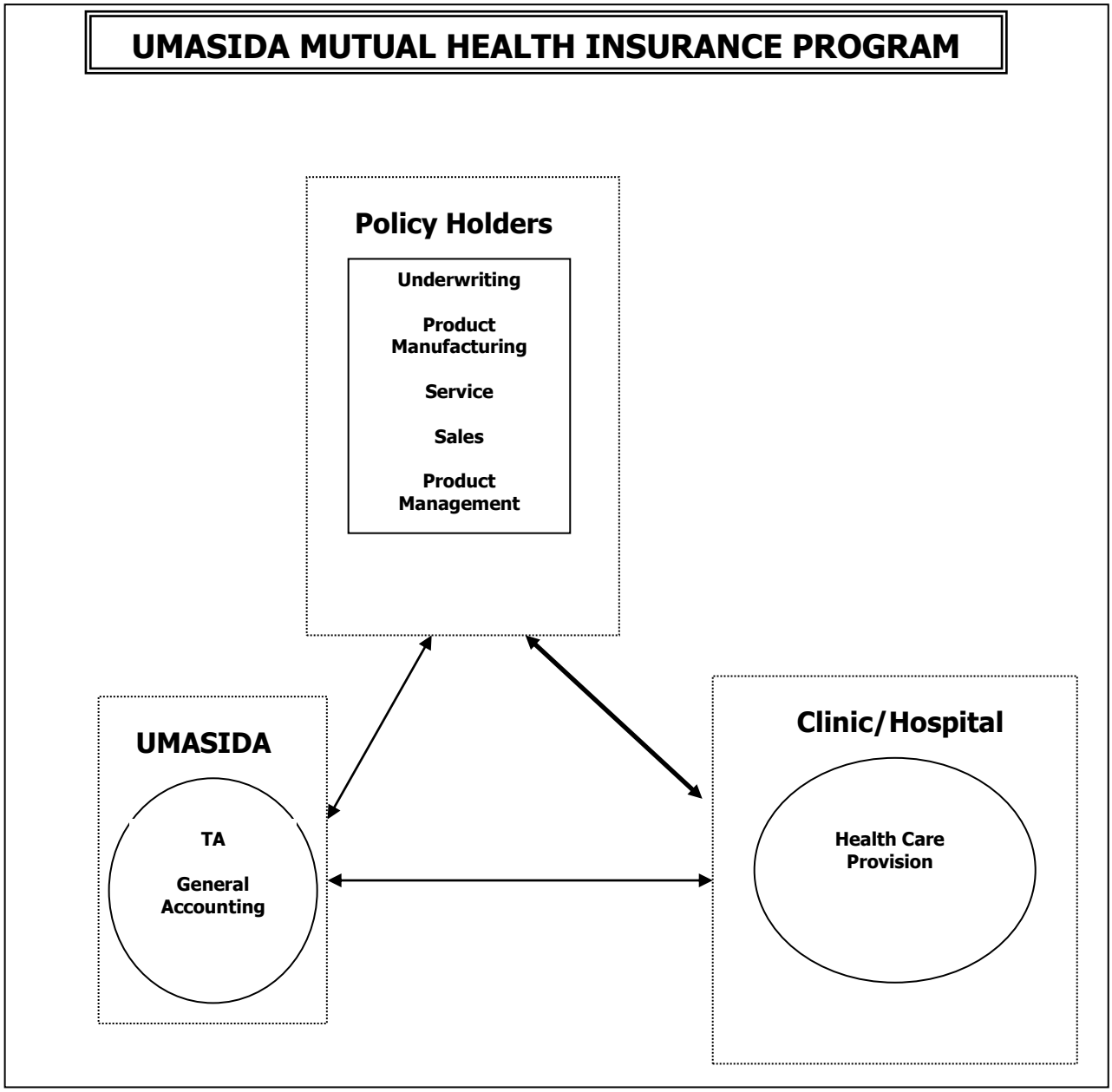
In the community-based, or "mutual" model, the policyholders themselves act as the delivery mechanism for the insurance. As the schematic below shows, the members perform virtually all the management of the program. There is project oversight from the UMASIDA office of Dr. Kiwara and a bookkeeper. This oversight was initially donor funded, but the funding has dwindled over time. Now the bookkeeper is paid through a precarious arrangement with the National Teaching Hospital and the Director states he is a volunteer.

Pre-qualification criteria for UMASIDA to work with a group are:

- groups must be "performing" as residential or workplace centered groups
- they should have 300 – 400 group members (with a total of 1,800 to 2,400 potential insured)
- they must have "stable" leadership

- the group must be "financially viable"
- women must have a significant role in the group and its leadership

No groups were rejected, though several dropped out of the program during the process.



The group leaders (with some assistance from UMASIDA) manage the clinic relationships, address any member issues, control access to service, and collect and protect the premiums. They technically set the price with their members, promote the program to others, and enforce most of the controls.

The selection of the clinics which UMASIDA groups contract for services is based on their internal objectives plus criteria set by UMASIDA. Group criteria usually relate to proximity, local reputation, and sometimes religious considerations (a Muslim group, for example, might want to access only a Muslim clinic).

UMASIDA criteria for clinics include satisfaction or agreement to the following:

- maintain a lab able to perform the five most necessary tests

- ability to provide primary care, immunizations, and preventive care
- ability to perform emergency deliveries
- 24 hour access to the clinic
- diploma holding nurses
- ability to give intravenous drugs
- willingness to adhere to essential drugs list (added later)
- willingness to receive monthly payments
- ability to invoice UMASIDA

Each group pays UMASIDA a collective premium on a monthly basis. These collective premium payments are consolidated by UMASIDA for centralized invoice review and payment. Although group management reviews the monthly clinic invoices first, they pass them along to UMASIDA for payment. UMASIDA reviews them for proper charges as per the agreement between the clinic and UMASIDA. They also perform a clinical review to assess for proper treatment. They do not pay for excessive treatment, shotgun treatments,[5] or medications not listed on the essential drugs list. Doctors report that they frequently have their bills returned for correction due to such problems. UMASIDA also acts as gatekeeper to the National Hospital – UMASIDA requires that the Hospital obtain pre-approval for hospital care in an attempt to limit moral hazard.

In addition, UMASIDA is primarily responsible for identifying and expanding the health financing plan to new groups. Active groups want their membership to increase to improve the size of the risk pool but have no incentive to market to other groups since their risk pool is limited to their group. Since insurance is a business of numbers, this is a limiting factor with this model.

Clinics provide the primary health care service. No doctors reported actively promoting preventive care, not surprising since their incentive is to care for more and more patients (this is the only way they earn money). Also, because of the long duration of payment of invoices by UMASIDA, the clinics have effectively become creditors of the program.

III.C. Costing and Pricing

UMASIDA management recognizes that pricing has been a disaster in their scheme. With assistance from ILO, they determined (from the World Development Report) that comprehensive health care for the urban poor should cost about US$1 per person per month. With concerns that members would not be able to pay this, some actual reluctance from the potential members, and some donor money to provide short-term subsidies, they decided to charge US$1 per *family* per month. There is no evidence that any costing model was used to help them determine a proper cost for the comprehensive care they wanted to provide. Thus, they started out with two serious problems in their pricing. (1) They priced the product way too low without any financial assessment, and (2) they got members to expect donor subsidies.

The donor subsidies (primarily for operations) quickly ran out and premiums were almost immediately recognized as too low. This required UMASIDA to increase prices several times, but this was not well received by members. Additionally, poor initial pricing also undermined the attempt to build adequate reserves. The initial reserves, established through the requirement of two months contributions prior to health care access, were built with woefully inadequate initial premiums and thus were quickly depleted. The pricing error of not adequately analyzing the costs of comprehensive insurance when setting the price has led UMASIDA to the brink of bankruptcy.

[5] Shotgun treatments are those in which the doctor is unsure of the illness and thus prescribes a broad range of drugs in order to combat several possible causes. This is expensive and dangerous for the patient.

IV. PILOT TESTING

There was no formal pilot testing of the UMASIDA mutual insurance scheme. No formal pilot testing objectives were set and no tracking indicators (except for basic client numbers) are evident (and even they are weak). It was clear that the scheme was rolled out to the target groups and although the ILO likely tracked broader data on these groups (because this was one component of a larger project), the health scheme was not formally monitored as a pilot test.

After six months of operations it was clear to UMASIDA management that the initial controls of the program were severely lacking and that the insured and clinics were taking advantage of this deficiency. The UMASIDA Director then suspended the program in September 1996.

This suspension allowed for a reevaluation of the control structures and the pricing. In a sense, the initial six months was treated in retrospect as a test phase. Although there were no tracking indicators and no objectives set, many of the issues that arose during the first six months were examined, and corrective actions instituted to address them. These are outlined below:

Table IV.1: Product Issues and Corrective Actions

Issues:	Corrective Actions:	Result
No control on "family" size so extended families were gaining service	Identification cards issued for insured plus clear definition of membership.	Definition of insured unit remains unclear to clients though cards have improved controls.
Though elected by the groups, many leaders proved corrupt	Group leaders changed in several groups	This is a recurring problem
Identification of members was unclear	UMASIDA instituted client identification cards that must be provided prior to service. In some cases, a sheet of photos of all insured clients was provided to the clinic.	Coupled with "sick sheets" identification significantly improved, though nighttime access controls remain somewhat weak.
Clinics prescribed expensive name-brand drugs	Implemented an essential drugs list of "sufficient" generic drugs	No drugs off the list are paid for based on review by UMASIDA. This has eliminated prescribing of non-listed drugs, though it has created a continuous complaint by insured.
Over-treatment and shotgun treatments by clinics	UMASIDA Director commenced clinical review of each case based on monthly billing	These have dramatically reduced because UMASIDA refuses payment for such treatment based on a detailed clinical review.
Problems of clinician understanding of the program	UMASIDA conducted seminars for participating clinics	Clinics and UMASIDA report them helpful but problems continue.
"Overuse" of services and member control problems	Introduced "sick sheets" which must show written approval by a group executive for each visit to the clinic before a doctor will see the patient (except at night when executive is unavailable)	Sick sheets provide better control for client identification, though have resulted in some unexpected negative results (see below).
Lacked confirmation of care	Circulating invoice was developed to confirm care and its cost and act as a backup for billing confirmation.	Circulating invoices have aided in the confirmation of care services provided

After close to another year of operations, the ILO conducted an evaluation of the UMASIDA scheme. The evaluators found several weaknesses, some noted in Table IV.2 below. These findings resulted in additional assistance from ILO/UNDP to initially employ a bookkeeper, educate clinic managers, and obtain an office (through assistance from the Institute of Development Studies of the Muhimbili University of Health Sciences).

One will note that several of these issues (insufficient premiums, group leader fraud, and clinic billing abuses) are continuations of issues identified in the earlier internal assessment, despite attempts to address them. Many of these issues were also seen as current issues during the July 2000 visit.

Some achievements noted from the evaluation include:[6]

- The scheme had expanded to three new groups
- The sick sheets and circulating invoices appeared to minimize member abuse
- They had obtained health care discounts of 20-30% for their members

Table IV.2: Additional Issues and Corrective Actions

Issues:	Corrective Actions:	Result
Serious accounting weaknesses from poor bookkeeping and records management	ILO/UNDP funded a bookkeeper position	Though the bookkeeper is personable and clients like her, the bookkeeping and record keeping remain serious weaknesses. She is now funded by Muhumbili University under a tenuous arrangement
Logistical difficulties for UMASIDA management	Office space and computer provided by the Institute of Development Studies of the Muhimbili University of Health Sciences	The office space provides a contact point which clients appreciate, but the relationship with the University is so tenuous that the bookkeeper is afraid to use the computer for fear that it will be taken away at any time.
Insufficient premiums	These were later increased to US$2.63 and then US$3.75)	Groups continue to experience claims-to-premiums deficits, and debts to clinics are increasing
Rampant fraud by group leaders	Instituted a lock box system where only UMASIDA management maintains a key.	Too early to assess impact
Billing abuses by clinics	Training sessions with health care providers, and increased diligence of UMASIDA billing review.	This action appears to have improved the situation.

Most of the adjustments made to the initial product itself were focused on pricing and controls, clearly the weakest areas of this scheme. Because the initial premium was set very low, UMASIDA has had to work to get clients to pay an amount that covers the groups' costs. The evolution of this process is best described by one former member who said:

[6] M.J.Msambazi, Issues on Health Insurance and Occupational Safety and Health Concerns of the Informal Sector; Tanzania Experience (Draft), IDRC Canada, September 1999.

> "In the beginning the premium was Tshs 600/= (US$1) per month covering my father, mother, my wife and two of my children. This, I think, was fair enough. Suddenly, without much explanation, the premium shot up to 1,000/= (US$1.45). At that point, most members stopped paying and the doctor stopped providing services. Many people later resumed. Then suddenly the premium increased to 2,100/= (US$2.63). This was annoying for it was done without much explanation. I dropped out at that point. I think the premium should be at 1,000/= because we are poor people who the donors are trying to help."

These comments illustrate that even in a mutual methodology, where members are owners, there can be a serious problem with communications. Since members returned to the scheme even with the higher price, it appears that the issue was more a lack of understanding than a lack of ability to pay. Yet, after this experience with the results of poor communications, UMASIDA again imposed a large increase without much explanation. In May 2000, the premium was increased again to Tshs 3,000 (US$ 3.75 per insuring unit).

Also evident in these comments from a former member is the expectation of donor support,. Similar comments were heard throughout the field visit. Members clearly expected donor funds to subsidize their schemes, not because they could not pay, but because they are poor.

The internal control issues of the groups have proved very difficult to address. Every group visited had experienced fraud from one or more of their leaders. Some examples of the fraud expressed by members during meetings include:

- Outright theft of premiums
- Exclusion of services. In one group all members paid for the insurance in a bundled premium (with market fees), but only executives and their families had access.
- The sale of sick sheets to non-members to profit the executive

It is clear that in this case self-management requires strong oversight. Many of these weaknesses have resulted in a downward spiral for UMASIDA. Poor pricing, executive fraud, and poor accounting yield cash flow problems that make it impossible to pay clinic bills. When the clinics are not paid for a few months, they issue quit notices to the groups. When clients are turned away from the clinics, they stop paying their premiums. This leaves less money in the premium pool. The cycle continues until no one is served by the clinics and no one pays premiums. Unless dramatic action is taken, UMASIDA will become bankrupt and the clinics, which take on much risk in this scheme, will lose their receivables from the groups.

V. ROLL OUT / IMPLEMENTATION:

The pilot testing and rollout phases were effectively simultaneous given the lack of formality in the "pilot test." Rollout infers a large increase in the number of members served and organizational evolution to accommodate the increased volumes. This has not happened at UMASIDA. Of the initial five groups with their nearly 500 insured members plus their families, only one group remains. After reaching a peak of eight groups and 823 insured members in September 1999, they have fallen back to six groups with about 300 insured members and their families. Identifying the number insured with clarity was difficult because of the state of the records at UMASIDA and because of discrepancies in member numbers reported versus those observed in the field (the excluded members and the flexible family sizes, for example).

The UMASIDA management has not made an effort to market the scheme to other groups because of the voluntary status of the Director coupled with his many other responsibilities. In retrospect, the lack of growth may be beneficial given the level of weaknesses in this program. Additional groups likely would have overwhelmed the systems even more than they are now.

VI. INSTITUTIONAL IMPACT

In the mutual model, the intended institutional impact is directed at the leadership and membership of the mutual group itself. Since the members are the "owners", managers, and decisions makers (at least in theory), their capacity must be built to enable them to properly manage their insurance business.

VI.A: Human Resources

These groups are comprised of market vendors and small manufacturers. They expressed a clear desire for an improved mechanism for health care financing. In PRA meetings, they stated an appreciation for the insurance. However, none stated a desire to run an insurance scheme. Almost all the group executives all indicated that they would not seek re-election because of the huge burden of scheme management. One treasurer stated that he spent two hours each day away from his business collecting premiums from his members. A mutual scheme imposes very heavy responsibilities and labor requirements on its executives in the name of member "ownership". It was not clear that members were looking for ownership, but rather simply better health care financing.

The structure of these schemes within the groups was rather simple, though labor intensive on a day-to-day basis. Training on the basic systems was conducted by UMASIDA and the executives seemed knowledgeable about the procedures. In more skills-based activities, like negotiating contracts with clinics, UMASIDA provides continuous capacity building. For example, UMASIDA requires a preliminary review of clinic invoices by group executives to help build group management capacity. However, UMASIDA management plays an important role in oversight not only of costs of the bills, but of the quality of clinical care.

Even with all this training, there are still significant accounting weaknesses. These weaknesses are not offset by the centralization of the premium pool at UMASIDA, but rather exacerbated by poor controls at the UMASIDA office.

An objective in all insurance is to increase the size of the risk pool in order to spread the risk further. With mutual schemes, as the risk pool increases, the capacity of scheme management is often quickly reached. When this happens, it becomes increasingly difficult to manage the scheme well, and this leads to rapid deterioration. In this case, although the basic procedures have been taught, it is clear that the control structure that holds the system together is too weak.

VI.B: Operations and Systems

At both the group and UMASIDA level, systems are manual. Because this was a completely new product to the groups, a new management team was elected to set up the scheme. Systems were developed by UMASIDA and transferred to the group leadership. UMASIDA provided training and a basic procedural guide.

VI.C: Feedback Mechanisms

There is an informal continuous feedback loop between the groups and UMASIDA management. This facilitates communications between the two so that when significant problems arise, UMSIDA management can assist group leaders in addressing them. Group leaders make use of this informal mechanism, and report that the guidance they receive is valuable.

Formally, structured periodic analysis of the schemes is weak to non-existent. Therefore, alterations to improve the schemes tend to be reactive. Procedural changes are directed by UMASIDA based on conjecture rather than on empirical analysis of data coming from the groups.

VI.D: Marketing

The scheme was initially marketed to eleven groups participating in a larger ILO project. Since then, marketing activities have been limited, with only six groups currently participating.

The UMASIDA Director has intentionally limited marketing activities for several reasons. First, even when there was funding, he was able to focus on this project less than half time and was very busy with other activities. Second, he wanted to see how the project would work before over-promoting it. Third, he recognized UMASIDA's limited capacity to oversee these schemes. Therefore, he directly marketed the scheme only to a few informal labor groups.

Within the groups, there are frequent informal marketing efforts to recruit new members. These are usually person-to-person efforts. Marketing has been difficult, however, because of low morale among members due to intermittent care provision and internal group difficulties coupled with the premium level.

VII: RESULTS

Objectives of UMASIDA were based on an ideal of creating a member-owned health care financing model to improve quality of employment and life in general for the clients. As noted below in Table VII.1, these objectives remain substantially unmet. In general, the reason the objectives remain unmet is a mismatch between what the poor in this market want (an efficient health care financing mechanism) and what they have been provided (a model that requires a very heavy administrative burden, forced reliance on corrupt leaders, and poor oversight from a higher level organization/body).

Table VII.1: UMASIDA Original Objectives and Results Observed

UMASIDA: Original Objectives:	Results Observed:
Develop a replicable self-financing model for satisfying health care needs of informal sector workers in Tanzania	With its precarious financial situation, the need for strong volunteer oversight, and the limited management capacity of the groups, combined with the poor internal control structure, it is hard to see these as sustainably self-financing. Already, satisfaction of health care needs is affected by the intermittent care provision resulting from excessive arrears in claims payments to clinics.
Create a structure that provides full program ownership to the users/members	In this model, members do have ownership with all the risks and responsibilities that come with it. It is not clear that such ownership is an objective of the members. Although groups make decisions on a day-to-day basis, UMASIDA management has a high level of control over the schemes.
Demonstrate how to improve the quality of employment through enhanced access to resources	The relationship between access to health care and improved quality of employment, though intuitive, has not been assessed with this program.

As seen in Table VII.2, members state that they have experienced better health and that the program has greatly assisted them in mitigating the financial burden of medical crises. At the same time, the expectation of ownership and the incumbent responsibilities are not what these people are looking for, and have in fact led to the near bankruptcy of the program.

Table VII.2: Community Based Groups Original Objectives and Results Observed

Community Based Groups: Original Objectives:	Results:
Improved health of members	Members report improved health because of the scheme, though expressed concern that many of them are no longer able to visit their doctors because of scheme finances.
Minimize health cost shocks to members	Members report that the scheme has assisted them when they have had medical issues. Several members report that they are adding their parents to the scheme, thus saving themselves significant amounts on parental health care issues.

As noted in Table VII.3, clinic management like the concept of gaining access to a pool of patients in the competitive market that Dar es Salaam had become. Especially in the early days of the relationship, several of these clinics increased their patient load by one-third just by virtue of the UMASIDA relationship. However, for most clinics the relationship turned sour when they had to start compiling detailed monthly bills that, as one clinic nurse who has to prepare them stated, "take two days to complete." Then came delays in payment, and in one case the refusal by UMASIDA to pay over US$400 in claims still due from mid-1999.

Table VII.3: Clinics Original Objectives and Results Observed

Clinics: Original Objectives:	Results:
Gain access to a stable additional patient pool, and lock them into service provision by the clinic	Dar es Salaam is now a highly competitive market for private clinics. This scheme did, in fact, provide a stable pool of patients to the contracted clinics. Some clinics report as much as 25% of their business came from an UMASIDA group.
Reduce collection burden through the billing system	The billing system itself turned out to be a huge burden with some clinics reporting that it took them two days to complete the detailed invoices required. Collection from UMASIDA was difficult as well. Clinics report that payment of invoices sometimes took months. Even then, some payments did not cover the full invoiced amounts.
Improve profitability	For a period, profitability in the clinics improved. However, with payments coming late, and sometimes not at all, clinics report that they are suffering losses.

UMASIDA management reports several anticipated benefits from working with the mutual model – a model that is so intensely focused on community participation. These are included in Table VII.4 with comments on what was actually observed in relation to these benefits.

Table VII.4: Anticipated Benefits and Benefits Observed

Anticipated Benefits:	Actually Observed:
Enhance transparency	Evidence showed high levels of corruption within the groups and significant scheming among group leaders.
"Ownership" will result in defense of program by members	Even with all the problems listed above, groups had to be pushed by UMASIDA to change their leadership. Member apathy makes one treasurer state that if he did not collect from his members every day, they would not pay the premiums. One group makes direct payments to their clinic when UMASIDA is in arrears.
Financial sustainability	Serious pricing and cash flow problems have led to near bankruptcy of the program.

There is no question that this program, if it is to be successful, requires strong oversight – oversight of a level that has been absent, especially recently. The benefit of "ownership" appears to benefit only the thieving executives, while it burdens the honest executives with significant inefficient labor and time requirements, and puts the "owner's" premiums at risk. These are common results of mutual programs in East Africa and elsewhere. It seems clear from discussions with members, and a review of results, that what these people really want is a better mechanism for financing health care needs. They are not interested in, nor do they have sufficient skills for, running an insurance company.

VII.A: Financial and Operating Results

Because the senior UMASIDA manager offers his time voluntarily and the bookkeeper is paid by the Institute for Development Studies, the primary financial issue is that of premiums versus claims. Because UMASIDA has no source of funds other than premiums to cover claims, it is critical that they maintain a surplus of premiums to cover the claims plus provide for a reserve.
Over the year ending 30 April 2000, UMASIDA experienced a claims coverage ratio of about 82% (for those four groups with sufficient data to assess). Of these groups, one experienced a positive ratio (115%) while the others were deficient in premium payments (claims ratios of 74%, 86%, and 96%). The latest round of premium increases to US$3.75 per month may improve this situation. However, the risk pool has dramatically declined and it is likely that the ill are the only ones left.

It is difficult to assess the actual financial situation of UMASIDA. According to UMASIDA records, the current individual group account balances with UMASIDA are as follows:

	Balance per UMASIDA at 30 June 2000 (US$)
Group 1 (Mfv)	76
Group 2 (Kek)	47
Group 3 (Bon)	(55)
Group 4 (Mba)	(382)
Group 5 (Vif)	84
Group 6 (Kor)	51
TOTAL	(180)

Thus, the UMASIDA records show a cumulative deficit of US$180. The bank statement at the same period shows a balance of US$22. The bookkeeper offered that there was neither cash on hand nor transactions in process to account for the US$202 difference. She was unable to provide any evidence to show that these accounts are reconciled. Controls on these accounts are extremely weak.

The premium payments from the groups were deposited into a single account and claims were paid from the aggregated balances. It appears that the payment of claims for the different groups were done through this account without regard to the balance available to each group. Though this effectively creates a larger risk pool, it has had the effect of allowing one group to completely deplete the premium pool and has put the premiums of all other groups at risk. Groups report that they get no formal statement of their account balances from UMASIDA and are thus unable to act as a control over their own funds, yet they retain the assumption that they have funds available. This adds to their confusion when clinics suspend services.

UMASIDA management offers that they had expected faster growth of both the number of groups in the program, and in participating members per group. This has not been realized with new groups because of a lack of marketing efforts. Growth in participation internal to the groups likely has slowed because of the internal corruption issues as well as the UMASIDA cash flow problems that have yielded service suspensions.

The problems are not just internal to UMASIDA or to the groups. UMASIDA reports several persistent problems in the operations of the clinics that prove detrimental to the program. These issues include:

- continued "shotgun" treatments
- "too many" tests conducted
- "supplier induced demand" whereby clinics are promoting non-essential drugs to patients
- "low quality" staff where clinics sometimes employ unacceptable providers
- "poor" diagnoses from clinic doctors

These issues are consistent with the intuitive expectation that clinics, like other businesses, will try to maximize their profits. One role of an insurer is to keep this tendency under control. In the UMASIDA case, UMASIDA management conducts cost and clinical reviews, which have been very helpful in controlling these costs. However, in the current structure, in which UMASIDA management is voluntary, quality oversight is unsustainable and continued oversight will eventually fall back to the groups. Group management is not equipped to provide the level of expertise required to control this tendency in the clinics.

Important ingredients to a mutual program are the strength and ability of the groups and their leaders. In this case, the Community Based Groups are weak organizations with limited abilities. When the oversight body (UMASIDA in this case) is also weak, a mutual program will have excessive difficulties and limited impact.

Client perspectives on the product:

Members report that prior to membership with UMASIDA their health care needs were financed through credit from family and friends, and sometimes directly from doctors, although all these resources were becoming more difficult to access. Especially if admitted to the hospital, many were forced to sell or pawn assets. Most commonly, people would simply postpone treatment until they could no longer wait. With medications, self-prescription is very common and people are often only able to buy partial doses, thus creating resistance issues, especially with regards to antibiotics. A person who had dropped out of the UMASIDA program relates:

> "Last week I was feeling very sick. I have high blood pressure. I was able to get treatment on credit from a doctor. However, I could not get the medicine on credit. Since I did not have all the money for the whole dose, I was given only a half a dose to match my money. Fortunately, I felt better and did not have to complete the whole dose. My doctor tells me that this is dangerous! Being a member of UMASIDA would have saved me from the potential dangers because I would have all the medication I need. But the group has too many problems. For now I pray that God will watch over me."

In order not to overburden the scheme, members were requested by UMASIDA not to "excessively" use the health care facilities. This is enforced using the sick sheet. The result is that insured members go for treatment when illnesses are at an advanced stage. In fact, doctors report that UMASIDA members come no sooner in an illness cycle than do non-insured patients. This suggests that insured members are waiting, or being forced to wait, until they are at a point when treatment will be more expensive both directly to the group and indirectly through loss of productivity of the ill person or their caretaker.[7]

Yet, members report in PRA groups that they are satisfied with the range and quality of their insurance coverage. Whatever illness they have, it can be covered by the scheme. At the same time, they express concern that they have to pay for care at the hospital and obtain reimbursement later. Several members stated that the reason they are in the program is because they did not want to worry about the case flow problems that illness or accident can pose, but this part of the scheme creates such cash flow problems.

[7] See the case study in this series on the NHHP and FINCA Uganda partnership where insured are prompted to go for care as soon as they feel ill.

Access to the hospital was stated as difficult because of the process that UMASIDA made them go through for approvals. One former member reported:

> "My mother was referred to the main hospital and I started chasing the process. The doctor informed me that I had to take his recommendation to the group leaders which I did. The leaders had to take the form to UMASIDA, get it approved, and get me the required money. Unfortunately, all the leaders were busy at that time. I looked at the patience involved and the pain my mother was going through and gave up the chase. I realized that it was easier to pay out of pocket. Because of such difficulties along side ever increasing premiums I decided to get out."

Members perceived the premium as high but explained that this comes from their understanding of this as a donor driven project from which they felt they should benefit. They commonly reported poor explanations given by UMASIDA on the reasons behind premium increases, coupled with inconsistent access to services. Although this was a member "owned" program, significant changes were made without their participation. Members report a general problem with communicating changes and suggested a standardized approach.

Because of serious management problems within the groups, several group representatives suggested taking the complete financial management role away from the groups. One member of a defunct group suggested:

> "If this scheme were to be revived we would need UMASIDA to take care of the finances. Our money is not safe with our leadership. Perhaps that is why services were terminated."

In Mbagala, as the premium increased from US$0.75 to US$2.63 in April 1999, membership fell from 73 (of 250 potential clients) to 50, a drop of one-third of insured, with no new members joining. The fact that less than 30% of the potential clients in the market were insured, even at the US$0.75 per month, suggests a problem greater than simply pricing given that there was significant knowledge of the program within the market. Based on discussions within the markets, this lack of membership is partly due to the distrust of scheme leaders.

Keko experienced a similar decline in membership. They started with 70 members paying US$0.75 per month in January 1999. In July 1999, with the premium at US$1.25, they grew to 105 members, and then to 107 in December 1999. When the premium rose again to US$2.63, their membership immediately dropped to 25, a loss of 77%. They have remained at 25 members through July 2000. This price increase coincided with the commencement of intermittent service from the clinic (clearly because the premium should have been increased or the coverage reduced much earlier).

For all its problems, members like the insurance. They like the ability to access good quality health care without having it cut into their cash flow, or require them to sell productive (or other) assets. They are willing to pay for the coverage. They almost all report that the problems they experience are due to the limited capacity of their own management. The mutual system has satisfied their basic needs (they report that they are in better health), but they see the structure falling apart, and want something better.

VII.B: Corporate Culture

A corporate culture has not been developed within the UMASIDA structure. Sub-groups were formed from larger market/workers groups and leaders were elected to manage the program. A self-help group was intentionally created through the model, and the management structure is non-professional and heavily burdened. The lack of both management professionalism and strong oversight have these groups in a weak business culture.

VII.C: Product Development Process

The product development process called for the creation of new structures within market/workers groups, and the creation of UMASIDA, the apex. All of these entities, as well as the clinic partners, needed training, some of which was provided by ILO, the rest by UMASIDA itself. Manual systems as developed have proven insufficient on both the group and the UMASIDA levels. Computerized systems are neither utilized nor necessary at this time.

UMASIDA did not track the cost of product development in this project.

VII.D: Plans for the Future

UMASIDA management plans expansion by bringing their program to more informal sector groups. They want to focus on growth in areas near their current groups in order to maximize efficiencies. They have also been contacted by the Government of Tanzania to expand to fourteen urban centres throughout Tanzania.

They recognize that they need to make changes in their model in order to improve controls, and are planning accordingly. Some of these plans include:

- Changing the identification system to one that would utilize an ultraviolet light housed at the clinic. Then a proof mark would be added to the ID card that would be invisible except under the light.
- Diluting the power of the executives through reducing their workload. They are currently assessing options to eliminate the sick sheet and thus the power that they give to the leaders.
- Improving insured member's confidentiality. Currently, sick members must explain their illness to the executive in order to get a sick sheet, and then the executives review the member illnesses based on the invoices. A new system would eliminate the sick sheets and utilize illness codes. Groups will then get a price list based on the codes, although it will be more difficult for groups to manage expenses.

VIII: SUMMARY OF LESSONS LEARNED

- ✓ Once people think the program is supposed to be "aid," especially in a formerly "socialist" country, it is very difficult to get them to recognize the need for sustainability. UMASIDA was promoted as a donor effort to help poor people to have access to healthcare.
- ✓ A group imposed gate-keeper function, such as the sick sheets, may have some impact in reducing moral hazard. The problem is that it forces people to wait longer for treatment, which is then more costly to the mutual. It also creates a disincentive to join, since people do not like explaining their illnesses to peers in order to prove that they are "sick enough" for treatment.
- ✓ One important ingredient to any potential success of this model is the quality, strength, ability, and integrity of the groups and their leaders. Some or all of these were lacking in the UMASIDA groups and this has made the program very difficult to manage. Typically, as groups grow in size to increase the risk pool, their capacity to manage the group diminishes.
- ✓ Proper pricing of an insurance product is critical from the start. UMASIDA has had great difficulty in bringing the price up to a level which matches the utilization of services by clients. It is much easier to reduce prices than it is to increase them without any perceptible change in the service. With UMASIDA, service got worse because clinics were not being paid while prices increased for clients in order to get the clinics paid – a deadly combination.
- ✓ Even with the inclusion of a requirement for the provision of preventive care, doctors and clinics limit that care to in-office advice. This is partly due to the incentive structure that promotes clinics seeing patients as often as possible in order to generate increased revenues.
- ✓ UMASIDA found itself in a continuous struggle to reduce costs and improve care at the clinics. Again, likely due to the incentive structure this model creates, clinics provided "shotgun" treatments, over-tested, promoted non-essential drugs to insured patients, and neglected

preventive care outreach, all of which potentially increase clinic profits at the cost of proper care.

- ✓ Any potential program success is highly reliant on a strong apex. The most significant benefit apparent with this apex was in the price and clinical review conducted by UMASIDA staff. Other potentially important roles include marketing, control setting, and oversight, all of which are critical to the program yet remain weak at UMASIDA.
- ✓ The community based groups of UMASIDA state a desire to improve their ability to finance health care problems, however, they do not state that this should be in a form that they must manage and control. It is the mechanism they want, and not particularly the ownership. Several members suggested that they would prefer that the mechanism be managed by an external source. They said this would reduce their labor, and provide greater confidence in management (assuming the manager/company is trustworthy).

Table VIII.1: Managing Insurance Risks: Strategies Used by UMASIDA in the Provision of Mutual Health Insurance

Risk:	General Strategy[8]:	Specific Strategy:
Moral Hazard	Pre-selected providers	1. UMASIDA intermediates between groups and clinics to agree on provision of services and the cost (usually at discount)
		2. A detailed contract is signed between the clinic and UMASIDA
	Claims limits	1. No clear limits
		2. There is a "gatekeeper" function conducted by a group executive that must approve all service. This has potential to act as a limiting factor.
		3. UMASIDA management must approve expenditures at the hospital based on doctor's referral. Clients report arbitrary decisions about care are made by UMASIDA in rejecting claims.
	Co-Payments	No co-payments, and where there are co-payments or cost sharing (in the state hospitals) these are covered by UMASIDA. This eliminates the power of co-payments to minimize moral hazard.
	Coverage restrictions	1. Will not pay for "shotgun" or excessive treatments (though not specifically stated in the contract)
		2. Coverage is "facility restricted" in that basic primary care is covered at clinics where costs are relatively high, and all other services are provided through the state run hospitals which are cheaper
	Loss review	Detailed review of claims for cost and treatment
	Exclusions	No specifically stated exclusions
	Waiting periods	1. Members are to wait two months from start of premiums payments (to build up reserve fund) but this is erratically evidenced.
		2. When members stop paying there is no waiting period for re-entry. The member must simply pay up the arrears. Sometimes even this requirement is waived. This creates a serious incentive TOWARDS moral hazard.
	Proof of event	Member must obtain pre-approved "sick sheet" from group executive prior to any service, clinic maintains a circulating invoice.
	Client identification	Laminated identification cards provided to each member.
	Pre-approval of treatment	1. Member must obtain pre-approved "sick sheet" from group executive prior to any service (this "gatekeeper" role enhances the potential for fraud and vested interest decision-making as well as deterring insured from early treatment).
		2. The policy is that general pre-approval of treatment is provided in the evenings by virtue of the ID card being matched with a photograph held by the clinic. However, only one of four clinics visited had such cards.
	Expense verification	Monthly case-by-case verification of expenses by both group and UMASIDA. (Has resulted in significant billing reductions.
	Clinical treatment verification	1. Monthly case by case verification of clinical treatment conducted by in-house physician. It is reported that the office manager has been trained recently to conduct this review.

[8] General strategies are taken from Brown, Warren and Craig Churchill. Providing Insurance to Low Income. Part 1 – A Primer on Insurance Principles and Products. Microfinance Best Practices project, DAI, Bathesda, MD, 2000.

Risk:	General Strategy[8]:	Specific Strategy:
		2. Frivolous and "shotgun" treatments are not covered (though this is not defined in the contract) and discovery of these by UMASIDA have reduced such activities by hospital staff and doctors
	Deductibles	No deductibles required
	Initial exams	No initial exams required since pre-existing conditions are not excluded
	Use of preexisting groups	Insured are drawn from existing groups usually related to their workplace.
Adverse Selection	Membership from existing groups only	1. Insured are drawn from existing groups but some take others from outside the group.
		2. Insured are supposed to have stability of home and workplace.
	Whole family membership required	Require "family" payment for two adults and four children. Insurance for additional "family" members is purchased in the same unit. Frequently the surplus "family" members are covered under one policy. Most related that one premium payment covered man and wife, the man's parents, and all the man's children. This was frequently evidenced and increases the risk without any subsequent additional inflow to cover it.
	Required membership within groups	No set percentage participation of members within the groups is required.
	Defined risk pools	No formal separation by differential risk factors noted. However, structure does provide for defining risk pools during the negotiations with the clinics, and there is some occupational separation by virtue of the group's membership composition.
	Waiting periods	1. Members are supposed to wait two months from start of premiums payments (to build up reserve fund) but erratic compliance was evidenced.
		2. When members stop paying there is no waiting period for reentry. The member must simply pay up the arrears. Sometimes even this requirement is waived. This creates a serious incentive TOWARDS moral hazard and adverse selection.
	Tying insurance to other products	Insurance is tied to other activities of the cooperatives and/or market groups.
Cost escalation	Periodic cost evaluation	1. Cost discussion occurs at negotiations with clinic and during subsequent meetings with UMASIDA.
		2. The group itself determines when the costs are too high and can renegotiate contracts with their present clinic or another.
	Preset pricing agreements with providers	Price list, with a percentage discount, is provided as part of the contract between the clinic and UMASIDA groups.
	Preset drugs list	A list of generic essential drugs is strictly followed.
Fraud and Abuse	Co-payments	None
	Computerized ID systems	None. UMASIDA states that clinics have client lists but these were in evidence in only one of four clinics visited
	Coverage limits	None, though all coverage requires group executive approval

Risk:	General Strategy[8]:	Specific Strategy:
	Financial Accountability:	Very limited at group level. Funds are collected and held by treasurer for up to a month, record of group balance held in UMASIDA account not in evidence at either group or UMASIDA offices. Frequent problems with group executives misappropriating funds.

Table VIII.2: Strengths, Weaknesses, Threats and Opportunities by Stakeholder

UMASIDA Health Care Financing Strengths, Weaknesses, Threats and Opportunities by Stakeholder STRENGTHS of the program with regards to each stakeholder		
UMASIDA	**Community Based Groups**	**Clinics**
Provides improved access by the poor to health care in that they can receive services without a large outlay of funds (except with state hospitals).	Premium collection matches client's abilities to pay (small payments often daily)	People are happy with the services provided at the clinic
Groups and individuals receive personalized care from the UMASIDA community worker / bookkeeper	Efficient mechanism for members making premium payments	Currently hold "monopoly" on treatment of group's members.
Clinical and cost evaluations done by Dr Kiwara improve accountability of clinics	Care improving as insurer reduces hospital "shotgun" cures and over treatment.	Clinics are proximate to insured's workplace
Improves access to all levels of health care (at least for a while until the money runs out)	Enthusiasm of clients (they like the concept, but don't like the work, the cost, or the fact that their service is getting cut off)	
Provides a stable pool of clients to private clinics	Communications with members is facilitated though frequent contact between executives and members.	

Table VIII.2, Continued

WEAKNESSES of the program with regards to each stake holder		
UMASIDA	Community Based Groups	Clinics
Risk pool vs. local capacity does not reach an adequate equilibrium in this program (or this model). As the risk pool grows to even minimally appropriate levels the capacity of the local executives to manage the program is surpassed.	Cash controls within groups are very poor. Most groups have had to evict leaders due to theft from the fund. UMASIDA's response was to give the groups lock boxes to which Dr. Kiwara holds the key. Several clients reported: "our money is not safe with our leadership."	Treatment has occasionally been through "shotgun" cures, and over treatment (this is improving)
No funding for central UMASIDA office and staff. Dr Kiwara says he volunteers his time for these groups, and the community worker/bookkeeper is paid by the hospital. This leads to poor supervision	Appears to be some adverse selection partly due to the one-month renewal periods. Late payers can get service if they make up the missed payments and thus promote an economic decision	Delays in billing UMASIDA causing difficulties for UMASIDA managers who have

WEAKNESSES of the program with regards to each stake holder		
UMASIDA	Community Based Groups	Clinics
	within the client (which cost more, the catch-up amount or the treatment).	arbitrarily rejected bills due to tardiness.
Incentive for prevention falls to group – The clinic has an incentive to see the insured as much as possible (to make more money from keeping them sick). Thus, preventive care is left to the group which has the least ability to provide it. This is a methodology issue.	Clients paying in arrears – It is the policy of several of these groups that if a family is in arrears they may clear the arrears immediately prior to (and sometimes after) gaining access to the clinic. This leaves people to skip payments and then decide if the care will cost more than the arrears.	
Reimbursement structure for government facilities. Clients must get permission from their groups, go to UMASIDA offices for permission from them and then they can go to the hospital.	Lack limits on family membership – family coverage is not clear and the terms appear somewhat flexible within the groups. Thus, people bring on their sickest relatives for coverage. Clients said this policy was cheaper than all the money they had previously paid to take care of their sick parents	
Payment delays to doctors – Some are more than six months late.		
Time burden on group management and doctors		
Risk pools are too small and are unlikely to ever be large enough to facilitate effective risk management.		
Pricing has been poorly calculated from the beginning resulting in frequent unexplained increases and essentially a bankrupt program.		
Utilization control system offers opportunities for bribery (evidenced) and a disincentive to seek services early on in the illness cycle since the executive will turn them away.		
Very limited to no reserves		
Communications from UMASIDA reported as generally poor by clients.		
Accounting controls at UMASIDA are very weak with basic essential procedures not followed, and accounts not reconciled.		

Table VIII.2, Continued

THREATS of the program with regards to each stake holder		
UMASIDA	Community Based Groups	Clinics
Doctors unhappy with payment arrears due to cash flow problems at UMASIDA leading them to send quit notices.	Client groups have no remaining reserves	UMASIDA is effectively bankrupt and clinics are likely to lose more money than they already have in this relationship
UMASIDA bookkeeper/community worker is paid and provided office space by unrelated hospital. This could be tenuous.	UMASIDA is unable to reconcile individual group balances with aggregate bank balances	Clinics absorb the risk of this program and are experiencing losses. They are unlikely to continue with this program given such losses
Project Manager/doctor is not a funded position and thus provides little incentive for a busy person to manage this project.	UMASIDA has paid claims that exceed group premiums from the central pool that they control, and thus even groups with surpluses effectively have no funds available to them.	
Members continue to expect this to be an "aid" project where donors pay for them to participate. With no aid and a need to increase premiums, a severe attrition rate has developed.	Clinics are sending quit notices and suspending services. This leads to a rapid inability of groups to maintain premium payments by their members.	

Table VIII.2, Continued

OPPORTUNITIES of the program with regards to each stake holder		
UMASIDA	Community Based Groups	Clinics
Strong demand exists for insurance coverage from a quality insurer.	Future options to access other hospitals	Significant excess capacity exists at the clinics
Because government provides the secondary and tertiary care at highly subsidized prices, the insurance focus could be on primary and preventive care.	When program expands to other hospitals, competition among them should improve care.	Clients' dissatisfaction with UMASIDA creates opportunities for clinics to institute their own insurance programs directly to the insured.
		Clinics have an incentive to being tied into group schemes due to the level of competition among private clinics. A careful insurer can leverage the strong demand on the supply side. This program is showing doctors that they need to be careful of the partners they work with on such schemes.