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Microinsurance In Uganda: A Case Study Of An Example Of The Partner-Agent Model Of Microinsurance Provision

NHHP/FINCA Uganda – Heath Care Financing Plan

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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 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 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 NHHP/FINCA product is an example of the Partner-Agent model. FINCA Uganda, FU, a Ugandan registered MFI with a large market and a strong desire to assist both its clients and itself, has partnered with the Nsambya Hospital Healthcare Plan, NHHP, a health financing entity to provide health financing coverage for its clients.[1]

Objectives: This study reviews the Partner-Agent Model supporting the relationship between FU and NHHP. 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: This study of the NHHP/FINCA Uganda relationship was conducted through a field visit during the periods 26 – 30 June and 10 – 14 July, 2000. The consultant conducted interviews and document reviews with all partners (NHHP, FINCA, and Nsambya Hospital), while Participatory Rapid Appraisal (PRA) and focus groups were conducted with clients, former clients, and non-clients by a team from ***MicroSave*** and ACDI/VOCA.

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1 The author wishes to thank the management, staff, and clients of NHHP, Nsambya Hospital, and FINCA Uganda for their time and candor during the research of this case study. Most of the information reported in this paper derives from discussions with them and their internal documents, which they kindly shared with the author. Additional historical information is included directly from the author who served as Chief Executive Officer of FINCA Uganda from April 1995 to February 2000.

Detailed accounting and claims records, as well as other relevant documentation, were reviewed to provide the base data for analysis. The PRA was conducted in order to gain an understanding of the perspective of the market.

A review of findings was provided to management of NHHP and FU, and discussed during the visit.

I. CONTEXT:

I.A: MACROECONOMIC & LEGAL ENVIRONMENT

The macroeconomic environment of Uganda is illustrated in Table I.A.1, below.

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

GDP (US$ Billions)	6.6
Population (millions)	21
Surface Area ('000 Km^2)	241
GDP/Capita (US$)	310
GDP Growth Rate (1997-8)	5.7%
GDP per Capita Rank (of 206)	180
Population per Km^2	105
Inflation (1999/2000)	10%
Exchange Rate (2000)(Uganda Schillings per US$1)[3]	1,500
PPP GDP per Capita	1,072
PPP GDP per Capita Rank (of 206 countries)	180
Infant Mortality (per 1000 live births) 1970/1998	109/101
Under Five Mortality (per thousand) 1970/1998	185/170
Maternal Mortality (per 100,000 live births)	510
Access to safe water (% of population) (1996)	34
Health Expenditure as % of GDP (public/private/total)	1.8/2.9/4.7
Health Expenditure per capita (US$)	14

I.B: INSTITUTIONAL SUMMARY

Table I.B.1: Relevant Institutions:

	NHHP	Nsambya Hospital[4]	FINCA Uganda[5]
Corporate Type:	Health Financing Project	Hospital	Microfinance Institution
Legal Structure	DFID Project Nsambya Hospital	Regulated Private Mission (Catholic) Hospital	Company Limited By Guarantee and NGO
Core Products	Health financing products	Health Care provision	Credit (savings are not managed by FINCA Uganda)
Start of operations	1998	1903	1992
Total Assets (US$ Millions)	<0.05	1.35[6]	1.84
Number of Clients	.8	83	20

[2] 2000 World Development Indicators, World Bank, Washington, D.C. 2000. pp. 12, 16, and 92.
[3] This exchange rate will be used in all calculations of current figures in this paper.
[4] St. Francis Hospital Nsambya, Annual Report 1999. (Assumes exchange rate of US$1=Ushs1,500)
[5] FINCA Uganda unpublished documents for January 2000
[6] Represents revenues for FY 1999

/ Patients (thousands)			
Number of staff	5	318	94

I.C: PRODUCT DESCRIPTION

Table I.C.1: Product Description Table:

	Health Financing Policy[7]
Target Market (client type):	FINCA Uganda borrowers and their families
Target Market (geographic):	Greater Kampala
Intended client benefits	✓ Improved health of clients and their families ✓ Improved financial stability
Product coverage	✓ In-patient medical care ✓ Out-patient medical care ✓ Surgical procedures ✓ Medications ✓ Tests ✓ Basic dental ✓ Optical consultation ✓ Maternity ✓ X-rays
Limitations	✓ Limited to $233 per cycle for any one illness, and up to 3 weeks in-patient care per three months for chronic diseases ✓ Limited to range of services provided by Nsambya Hospital except for Dental which is outsourced, and medications which are outsourced when necessary
Exclusions	✓ Continuous medication for chronic diseases ✓ Treatment and consequences of alcoholism and drug addiction ✓ Treatment not scientifically recognized ✓ Injury or illness resulting from intentional participation in riot, civil commotion, affray, political or illegal acts ✓ Intentional injury or illness ✓ Infertility treatments and investigations ✓ Cosmetic Surgery ✓ Hearing aids ✓ Complex dental surgery other than as a result of accident
Eligibility Requirements (and renewal terms):	✓ Must be FINCA borrower ✓ Eligible at the start of each loan cycle ✓ At least 60% of the FINCA group must buy the insurance (to balance adverse selection with marketability)
Pricing (premiums)	✓ Basic cost: US$15.60 for four months covering client plus three others in household ✓ Each additional adult = US$ 4.63 ✓ Each additional child = US$3.20.
Pricing (co-payments)	✓ US$0.66 for each outpatient visit during business hours ✓ US$1.00 for each outpatient visit outside business hours ✓ US$1.33 on admission for in-patient treatment

[7] From product marketing documents

	Health Financing Policy[7]
Other	Clients are issued an identity card for themselves and their families. These are kept physically by clients and electronically by NHHP (for verification purposes)

II. MARKET RESEARCH

II.A: MARKET DEFINITION/SEGMENTATION

II.A.1: NHHP

For about a year before designing and implementing NHHP, the manager of NHHP had been providing technical assistance to, and supervision of, several health financing schemes in Southwestern Uganda. The clients were mostly members of cooperatives or school children at boarding schools. Several rural mission hospitals were involved, and the manager used them in testing and improving the health financing methodology.

In 1998, Nsambya Hospital expressed interest in working with such a health-financing scheme. The hospital is Roman Catholic and has a mission component. Their market is generally drawn from the upper lower class to the wealthy from greater Kampala. They wanted to expand their market share in their competitive environment, and were interested in developing a simple patient care financing mechanism that could facilitate the very poor. This specific market focus included individuals from the local markets and small businesses, as well as individuals who had only periodic income.[8] Thus, at the end of 1998, Nsambya management invited the management of what became the NHHP to come to Nsambya and create a plan for this market.

From their previous work in the rural areas, the management of the new NHHP program knew that one of the biggest difficulties for the poor in making premium payments was a lack of savings mechanisms. Clients could pay for premiums, but generating the lump sums to pay them was recognized as difficult. At the same time, very frequent premium collection was seen as inefficient. They needed a mechanism to assist clients in saving for the premiums.

Additionally, they learned that strong groups made the work of the scheme much more efficient. Groups helped enforce timely payment of premiums and screened out adverse selection, as well as improved efficiency of the scheme. Thus, when they came to urban Kampala they recognized that the clients of group-based microfinance institutions would comprise an ideal primary target market because of the strong groups and the understanding and accumulation of savings among their clients.

II.A.2: FINCA Uganda

In 1996, FU management recognized that the greatest deterrent to on-time repayment within its client groups is illness. Whether it is the client herself that is ill, or any member of her family, the woman of the family (and virtually all FU clients were women) is obliged to care for the sick person. These obligations usually result in a temporary suspension of her business and simultaneously rising expenses, sometimes leading to loan repayment problems and decapitalization of the business. Additionally, illnesses are often addressed late in the illness cycle because of financial and time constraints (i.e., waiting until the illness is so critical that it must be dealt with). This frequently results in a need for much more expensive treatment than if the illness had been treated promptly. FU staff saw many examples of clients who had significantly improved their household condition over time, only to be pushed back into severe poverty by the burdens of a family illness. This led FU management to informal discussions, seeking mechanisms to provide a health-financing product to their clients.

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[8] Based on discussions with Dr. Kizza, Medical Superintendent, Nsambya Hospital during the week of July 10 – 14, 2000.

Noting the complexities of offering health insurance, FU management recognized that this was significantly outside the realm of their core business and the expertise they had developed to support it. Direct health financing was deemed beyond what an MFI should manage, especially while working to build up the core business (provision of credit services and oversight of small groups with savings).

Previous experience also provided specific warnings against providing health insurance for clients. FU management had already tried providing health insurance to its staff on a reimbursement basis, which proved time consuming and fraught with fraud. They then purchased health insurance policies from a formal sector insurance company, which also had difficulty addressing the fraud issues. This company's health insurance line finally collapsed under the weight of abused loose controls. FU management then went back to a reimbursement system for staff, which again was time consuming and fraught with fraud. They finally recognized that they were not insurance managers, and that the insurance business is significantly different from the credit business in terms of operations, risks, and staff capabilities. Thus, they continued to look for an insurer for both staff and clients.

In making a decision not to directly provide health insurance to clients, FU management reviewed its own strategic plans. These included dramatic increases in scale and geographic coverage, the substantial reconstruction of its credit product, a significant broadening of its product line and market niche, and moving towards possible licensing as a regulated financial institution to legally intermediate savings. Given these plans and the recognition of how slowly and labor intensively change takes place in Uganda, it was deemed prudent that management attention and energy not be diverted to a new and significantly different business.

II.B. Market Research

II.B.1: NHHP

NHHP made presentations to several regional MFIs in an attempt to promote their product. FU was very interested from the start, but NHHP was unable to attract any other MFIs.

NHHP needed to research the level of interest and client ability to pay premiums, and identify an appropriate product mix. Twelve groups meeting proximately to the hospital were selected as the research sample. The selection process was simple. NHHP briefed the relevant FU credit officers (those working with the twelve groups) about the product, and had them ask their clients if they wanted any information on the plan. The NHHP staff visited the twelve groups since all expressed interest, and anticipated that these groups would comprise the first phase of the planned test.

In their visits with the groups, NHHP staff discussed the concept of health insurance, what the clients might want regarding coverage, and how much they could or were willing to pay based on what they would get. These were informal discussions and documentation was not compiled. The level of stated interest was strong and NHHP then moved on to product refinement and marketing.

The NHHP director and the technical advisor spent about one month of time over a period of two to three months further researching the market. They met with FU credit officers in the field and with client groups at regular group meetings. They also held several meetings with relevant FU staff (including the Country, Credit and Training Directors as well as credit officers during their regular Friday meetings).

The results showed very strong interest in a health-financing program, and helped define the product and its cost. Relative to the cost, it had been the objective of NHHP from the start that this program would generate surpluses within the first two years. Thus, although they discussed pricing with clients, they recognized that final pricing had to be based on cost components. The pricing discussions helped NHHP to better define the level of coverage within the prospective client's ability and will to pay.

II.B.2: FINCA Uganda

FU's research was rather basic. Management recognized the potential demand for health financing among its clients. What they needed was "simply" an insurer to offer a product that could work for their clients. Thus, FU's market research was focused on finding an insurer that had strong controls and accountable procedures. FU also wanted an insurer with a desire to service this market coupled with an ability to be flexible enough within a controlled environment to provide what FU's clients would buy. FU management reviewed the other programs that the NHHP management had supervised, and held several discussions with them to understand better their methodology, controls and plans.

II.C: COMPETITIVE ANALYSIS

II.C.1: NHHP

NHHP management and others (DFID, ILO/STEP, USAID DISH) had started health financing schemes mostly with groups in rural Uganda. These groups included cooperatives and boarding school students. In Kampala there were several very small schemes developed directly between groups of insured and specific providers (similar to the Mutual type of insurance provision). Commercial insurers were limiting their entry into the general health financing area due to severe fraud (related to poor methodologies and poor controls) experienced by others. Thus, NHHP had no significant competition in this area. In fact, health insurance programs even for the middle class were very limited, and since its inception, this product has attracted strong interest from groups of formal sector employees.

II.C.2: FINCA Uganda

When this program commenced, there were no MFIs interested in a health-financing scheme for clients except for FU, even though NHHP made an effort to attract them. Of the MFIs that chose not to test this product, several were not satisfied with the level of commission that NHHP would pay them for access to their clients. Some were concerned about distracting their staff and/or clients during a time when their organizations were adjusting to changes or addressing systemic issues. Still others simply did not find the product to be something they wanted to provide.

Like FU, most MFIs had not started their own health financing programs because of the same recognized risks, capacity, and administrative problems. FU perceived significant indirect dividends from this product, including improved performance for the groups (attendance, growth in loan values, and individual on-time repayment, for example), improved client retention, and a competitive advantage over other MFIs. For these reasons, FU management decided that the NHHP product was well worth testing.

III. PRODUCT DESIGN

III.A. PROTOTYPE DEVELOPMENT AND TESTING

Development of the health-financing product was almost entirely conducted by NHHP. For FU clients they used a methodology that had been developed for other groups (cooperatives and student groups), with several adaptations to improve it for MFI clients. FU provided access to client groups so that NHHP staff could test, on a discussion basis, the likely success of their product with FU clients. A prototype was addressed in discussion, but not formally tested.

Table III.A.1: Primary objectives of concerned parties in the health financing scheme:

NHHP:	FINCA Uganda:	Nsambya Hospital:	Clients:
Improve client health	Increase client retention through improved repayment (fewer clients to be discharged for poor payment history)	Gain access to new patients	Improve health of themselves and their families

Test their model	Improve individual repayment rates through minimizing health cost shocks	Reduce collection burden through single source monthly claims	Minimize health care financing shocks
Cover all costs	Improve attendance at group meetings through improved health	Improve profitability from increased collection efficiencies and reduced default	
Increase the size of their risk pool	Improve savings rates through improved productivity resulting from better health	Provide a health funding mechanism for periodic workers with inconsistent incomes	
	Increase average loan balances (and thus profitability) due to improved retention		

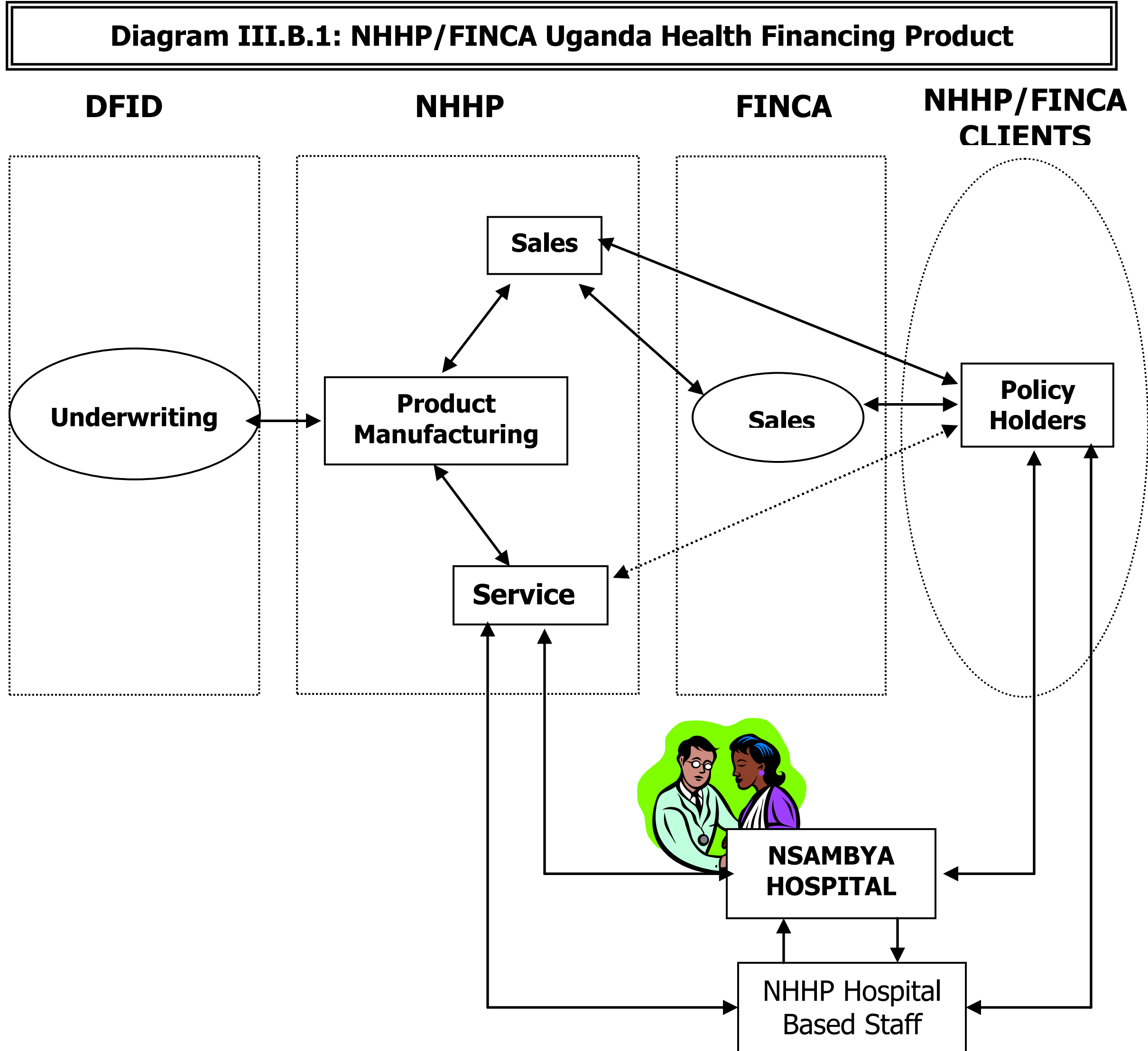
III.B. DELIVERY CHANNELS AND PARTNERSHIPS

One of the hurdles of extending an important product like insurance to a new market is finding an efficient delivery channel. This is particularly true for products offered to the very poor.

MFIs have an efficient delivery channel to the very poor and a desire to offer quality insurance products to their clients, but do not have the expertise and reserves to develop and manage an insurance product. Insurers have the product and the reserves, but do not have an efficient delivery channel to this sector. These respective assets and needs are what make a partnership between MFIs and insurers so potentially perfect.

Since NHHP developed and adapted the product intentionally to make use of the MFI/Insurer synergies, their integration into the FU network was reasonably simple. The health financing program breakdown of activities is shown in Diagram III.B.1.

In this case, FU simply offered NHHP access to its clients. Their sales role has been minimal, basically amounting to introductions. They do assist clients with some preparation of the premium transaction to NHHP (though this is a transaction directly between the clients and NHHP) and provide a potential feedback mechanism for NHHP to gain further insights on its product. In the testing phase, this minimal role was seen as necessary by both FU and NHHP to allow NHHP to begin the test quickly and to provide accurate information to potential clients. This also served as an informal training period for the FU credit officers as they watched the sales techniques and learned from the explanations of the NHHP staff. In the future, as volume begins to increase, it will be necessary for FU staff to take on more of a sales role, though both parties will work to minimize this as much as is practicable. At this point, staff incentives may need to be introduced for FU credit staff.



DFID has agreed to cover deficiencies in claims and operations costs above the level of premiums paid by the client. This critical reinsurance role protects clients from loss during the insurance period. NHHP has no reserves which would normally be the first line of defense for an insurer when claims costs supercede premiums paid. The next line of defense is reinsurance, which NHHP is ineligible for since they are not a regulated insurer. The role of DFID in reinsuring this program (through a local association of community insurance schemes) is what makes this program possible. However, it is possible that an insurer might price differently because of the protection provided by the donor. It is important that both the insurer and the donor ensure that the product is priced commercially and if found inappropriate, altered rapidly.

III.C: COSTING AND PRICING

The NHHP product price was developed through consideration of a costing mix that included an estimate of claims costs, operating costs and an allocation of reserves based on projected surpluses. NHHP management identified three levels of basic allocations:

- √ Health care claims from Nsambya Hospital (and affiliated dentists and pharmacies) for care of insured patients

- √ Operational costs of the NHHP staff located within the hospital at the NHHP reception window
- √ The cost of headquarters staff, operations, and reserve allocations

From the start, it was expected that the NHHP first and second level activities would be covered by premiums. As the risk pool grew (with coverage beyond one MFI and one hospital) it was expected that the headquarters costs would be covered and self-generated reserves would be built. Thus, the initial pricing was set to follow these objectives. The model developed by the NHHP managers helped them to analyze the costs versus anticipated utilization in order to develop a price. However, because good health care data is not available in Uganda, the NHHP team used data collected in rural Southwest Uganda where they were overseeing several similar programs. They utilized the rural data and inflated it in an attempt to adjust for urban usage levels.

Three factors were expected to dramatically increase initial demand for services, allowing NHHP to test the system with maximum stress during the testing phase:

1. **Satisfaction of Pent-up Demand:** Many clients were expected to have had persistent illnesses, aches, and pains that they had not dealt with because of cost issues. It was expected that these clients would want to address their health problems once they had insurance. In fact, this was the case during the initial phases of the coverage. In one example, a client (whose husband is a police officer that has special access to "free" medical care) related that she and her family "were perpetually sick, and now all our (medical) problems have been solved."[9]

   Most insurers would exclude pre-existing conditions as a mechanism to protect themselves from adverse selection. NHHP saw that clients would get no benefit from the financing if they remained sick from prior illnesses.
2. **The Doubting Testers:** Even if clients were not actually ill, it was expected (and witnessed) that some clients would develop an "illness" just to test out the system. People in urban areas are especially accustomed to schemes that cheat them out of their money and it was expected that they would want to test out the system immediately. Many did just that.
3. **Location:** There is an anecdotal correlation between the distance a person resides or works from a health care center and health care utilization. NHHP management intentionally tested the product on people living proximate to the hospital so that they could expect a higher utilization rate in the test phase.

The first two of these issues are expected to be individually short term. The third will remain individually persistent, but in aggregate is anticipated to minimize itself as the risk pool expands beyond the hospital's locale. However, after nine months, high utilization has continued as insured fully realize the potential of the program for satisfying their needs. This phase, if it in fact is only a phase, was initially expected to last between 12 and 18 months before insured settled down to more "regular" utilization.

Pricing discussions were held with clients, resulting in a price reduction of about 10%. Although it is necessary to work with clients to assess their needs (as was done here) it is difficult to find a proper balance between coverage, and premiums that clients will pay. People everywhere want to pay as little as possible to get as much as possible. This makes the results of pricing discussions with clients difficult inputs to a pricing decision. This is not to suggest that pricing discussions have no value, but that these discussions are of limited value and the institution must be careful about the decisions derived from them. One technique that may help to improve the value of this information is the PRA technique of "Pair-Wise

[9] Translation by Leonard Mutesasira from a PRA meeting.

Ranking" that could help to identify a balance between acceptable coverage and affordable price. [10] This technique was not used in this case.

It is important to note that there is usually a significant difference between a client's stated "ability" to pay and her/his "willingness" to pay for a quality product. Many institutions, especially NGOs, use a pricing discussion, where clients identify their "ability" to pay, as the key input to the pricing decision. This invariably leads to problems, often as extreme as cancellation of services due to a failure to cover costs. Although stated ability to pay was taken into account to a small degree by NHHP, the overriding stated goal was their coverage of costs.

With these assumptions and discussion results, a four-month premium was set at Ushs23,350 (US$15.57) per 4 family members (consisting of the client and up to one additional adult with the balance children), or an average of about US$1 per person per month. The four-month insurance coverage period was set to match the FU loan cycle, and clients pay the premium at the beginning of each four-month loan cycle. Additional adults were to cost Ushs6,950 (US$4.63) per four-month loan cycle and additional children cost Ushs4,800 (US$3.20) per four-month loan cycle.

IV. PILOT TESTING

The health-financing product was to be tested in two phases. The first phase was intended to last 6 months, long enough to enlist the members of six to twelve groups (120 to 240 clients, plus families), have them actively receiving services for one cycle, and then reapply. The second phase would then increase the number of clients covered to 1,000 plus their family members. Full rollout would occur after about one year. At the time of the study visit, the first phase had been completed and the second phase was delayed as discussed below.

The Health Financing product had been tested on other group programs in Southwest Uganda. FU was the first MFI to test the program in an urban environment. The product as originally designed is described in Table IV.1: Elements of the Concept.

Table IV.1: Elements of the Concept

Terms, conditions and coverages:	Reasons:
Voluntary offering	Wanted clients to understand the product (this occurs best when the product is sold to a client). Also wanted NHHP to understand the real demand for such a product (best understood when people reach into their pockets and give you hard-earned money).
Required 60% of members of group to participate	It was recognized that the 100% requirement of the Group Personal Accident policy restricted marketability, yet a mechanism was needed for minimizing adverse selection.
Cover in-patient, out patient, pharmaceuticals, basic dental and basic optical (details below)[11]	Wanted to provide a full range of benefits to clients and their families based on a belief that people need full care or they will not remain interested buyers, and they will not be completely healthy. It was recognized as an expensive option, but NHHP thought that if they offered what people wanted, people would pay.

[10] Further information on Pair-Wise Ranking and other PRA techniques can be acquired through the ***MicroSave*** website at www.***MicroSave***.org

[11] According to clients needs NHHP schemes can cover the following: Casualty and outpatient services; in-patient services; referral for consultation with consultants recognized by Nsambya Hospital; surgery; special investigations including X-ray, ultrasound, electrocardiogram and laboratory facilities available within Nsambya Hospital; pharmacy: drugs prescribed by the Nsambya hospital medical practitioner within the agreed treatment protocols of the specific scheme; maternity coverage; dental care including cavity filling, tooth extraction and general consultation; and optical consultation.

Four month insurance cycles	To match the loan cycles and provide a marketing benefit (if clients wanted the insurance they would have to borrow)
Collection of client funds at meetings paid directly to NHHP	This minimized the administrative burden on FU
All dealings with the hospital would be between NHHP and the clients. FU would have no need to deal with hospital administration.	This minimized the administrative burden on FU and placed the intermediary responsibility on the insurer
ID cards produced and computerized for each client and family	Minimize fraud
Pricing for surplus	There was no intention, from the start, for this program to be donor dependent.
Small staffed reception units would be installed in the hospitals	Minimize fraud and manage data
Co-Payments	To create a disincentive to frivolous usage
Limitations of $235 per single illness and maximum three weeks inpatient care in three months	To restrict coverage for chronic illnesses (symptoms of chronic illnesses are treated)
Exclusions (detailed below)[12]	Minimize expenditures

This concept was approved by FU for its clients. After the first cycle of the pilot testing period, the changes documented in Table IV.2 were made based on the test experience and agreed between FU and NHHP.

Table IV.2: Elements of the Concept: Alterations

Concept:	Alteration:	Reasons for alterations:
Exclusions noted in footnote 20	Added to exclusions: infertility investigations and treatments	Expensive and popular for treatment of a non-life-threatening issue
Pricing for surplus	Price to be increased by about 30%	Original pricing covered 75% of claims and none of local administration costs, even though objective was for a surplus. The price is expected to come down as the test is expanded and the risk pool increased. The increase occurred by virtue of adjusting the coverage period.
Four month insurance cycles	The period was shifted to three months at the same price (leading to the above price adjustment)[13]	It was thought that retaining the nominal price, but shortening the coverage period would be a more palatable way to increase the overall price to clients. It was also thought that an insurance cycle of a different duration than the loans might help FU to retain clients by keeping them in the insurance program over the cycles.

The health financing product diagram (As shown above in Diagram III.B.1) shows very little activity on the part of FU. FU's primary role in this relationship is providing access to their clients. They handle no

[12] The scheme will not cover: Complex dental surgery other than as a result of accident; Optical appliances (e.g. spectacles); Sight correction other than general optical consultation; Hearing aids; Cosmetic surgery; Intentional self inflicted injury or illness; Injury or illness arising out of intentional involvement in riot, civil commotion, affray, political or illegal act by a member (including imprisonment or detention by any authority); treatment not scientifically recognized and their consequences; Alcoholism or drug addiction and their consequences.

[13] This adjustment, though stated as policy, was not effectively implemented.

financial transactions and no paperwork. They do provide a conduit for feedback and have the capability to process the premiums, for a fee, if that becomes necessary or more efficient for the whole system.

The health financing product testing applied some of the lessons from the initial offering of the Group Personal Accident program (for which FU partnered with AIG). At FU, a protocol for the test was developed. The protocol detailed the following:

- √ Objectives
- √ Team members
- √ Duration
- √ Locations
- √ Resources / personnel required
- √ Training issues (staff and clients)
- √ Data to be collect with respect to the objectives
- √ Periods of analysis for specific data
- √ Evaluation periods
- √ Feedback and review mechanisms
- √ Decision periods

Testing protocols are important because they delineate the areas in which data must be collected. In preparation for the needs of decision-making, each party should develop a clear testing protocol, with detailed reporting requirements, before the start of the test. Then, the protocol should be followed. It is imperative that each party of a pilot-testing scenario collects the specific data they need in order to make rational decisions. The issue of data collection for decision-making is important. Without proper data, a company cannot make rational decisions about its business.

In this case, there are four related entities; NHHP, Nsambya Hospital, the Clients and FU. Each of these has different objectives for the test, each (other than the clients themselves) needs its own testing protocol and each needs to collect different data to address particular objectives.

FU had developed a protocol that was reasonably detailed and should have guided the test from FU's side. FU's objectives (as indicated in Table III.A.1: Primary Objectives of Concerned Parties in Health Financing Scheme) required the collection of very specific data. Unfortunately, the protocol was not followed, and the data was not collected. This resulted in very limited data for decision-making. FU thus relied on data obtained from NHHP to make decisions about its satisfaction with the product. However, the NHHP data was not sufficient for FU to make decisions regarding their objectives (since the objectives for each entity were different). For example, NHHP had neither the interest nor the access to data in order to track the attendance at group meetings, or the repayment by clients on a weekly basis.

The pilot test was directed at about 360 families from twelve groups selected for the trial. Of these groups, six were able to meet the 60% membership requirement, and 122 clients of 203 members of those groups joined.[14] The test was set to last about 6 months (until all six groups had concluded a four month service cycle and had an opportunity to rejoin). Among the reasons clients say they did not join include:

- ⇨ **Religious issues:** Many clients in the selected groups are Muslim and found a Catholic hospital unacceptable for their care, though many of them suggested this is more an issue for their husbands.

[14] The overall ratio of insured to group members was 60.1%. Two of the groups were approved even though they were only able to mobilize 48% and 51% of the total membership.

- ⇨ **Proximity issues:** Several clients in selected groups indicated that their residence is significantly closer to another acceptable quality hospital and thus did not want insurance for a hospital that was further away. The proximity issue seemed most relevant with regards to having other hospitals closer to their home or work. It was found that some groups residing and working as much as 40 miles from Nsambya were interested in the program because there were no acceptable hospitals near them. Thus, if they had to come to town for treatment, there was no particular geographical preference among the private hospitals.
- ⇨ **Confidence issues:** Because Kampala has been rife with financial scams, many potential clients preferred to wait to see if their more trusting (or gullible?) friends who obtained the insurance were actually served adequately.

The groups selected were chosen because of their proximity to the provider, and most of them resided or worked within about 5 km from the hospital. It was expected (and seen) that people who had not been insured previously would utilize the service to address issues of "pent up demand" (long lasting aches and pains that had gone untreated due to lack of funds). Additionally, it was expected that many of those without pent up demand would visit the doctor just to confirm that the service corresponds with that advertised. Finally, it was also clear that those residing or working most closely to the hospital would tend to use it more frequently simply due to proximity. Thus, the test was designed to illicit maximum utilization in the first phase for three reasons:

1. To test the impact of heavy utilization on the system
2. To push the systems as if there were many more insured
3. To assess pricing adequacy

Right from the start, NHHP wanted a price set high enough to cover costs so that as the client numbers grew and the utilization settled into normal patterns, the price could be reduced. As with almost all products, the market is much happier when the price is reduced than when it is increased. Additionally, future reductions in price were expected to attract "poorer" clients who might have deemed the initial cost too high, or who might have deferred participation until the demonstration effect had been fully felt.

Several issues arose during the testing period. These are outlined in Table IV.4.

Table IV.4: Issues of Testing

Issues:	Corrective Actions:
Pricing was not sufficient to cover costs (76% in months 1-3, 87% in months 4-6, and an aggregate 74% for months 1-8 covering claims only, with nothing for operations or reserves).	Price was to be increased by 30% for subsequent cycle (though the increase was not effectively implemented by NHHP)
Clients were obtaining expensive fertility treatments	This coverage was honored, but excluded from the subsequent cycle
FU was not tracking their testing data	Some data was collected in arrears, plans were made to improve collection and analysis
Procedures for patient visits outside regular business hours were confusing	Plans made to increase NHHP coverage to 24/7. This had been held back until significant volume was reached.
Significant billing errors and "shotgun" treatments viewed.[15]	Need of cost and diagnostic review confirmed. NHHP was strong with hospital. Bills and treatment

[15] "Shotgun" treatments are those in which a doctor provides an array of drugs to affect a broad range of issues often because they do not know the real problem. This treatment can prove very expensive and is usually not appropriate or professional care.

	improving.
People wanted flexibility to choose from more than one hospital.	New hospitals are being approached for this program.

A significant feature of this health-financing scheme is that it was designed to be implemented as short-term coverage. This provides an important benefit to the insurer especially in the testing phases, since alterations can be made rather quickly, limiting significant losses from mistakes in design.

V: ROLL OUT / IMPLEMENTATION:

The health-financing plan is yet to fully roll out. Phase One of the product test was to be completed in March 2000, and Phase Two of the testing is yet to be fully implemented. The delay has been caused by problems relating to an institutional transformation of the insurer.

NHHP was initially operating as a semi-independent unit within Nsambya Hospital. They maintained separate offices, separate staff and a separate payroll. They managed and controlled the deposit account into which the insured clients paid their premiums. They were not overseen by the hospital administration, although the hospital auditor was reportedly charged with auditing the books of NHHP each six months. The Hospital Administrator was quite clear in declaring that he wanted a strict separation between the hospital and insurer. He said that he needed the insurer to be separate from the hospital to reduce the opportunities for fraud and improve the operations of the hospital. He stated that by having an independent bill payer scrutinizing the bills from the hospital, this would improve the care of patients (by calling into question "shotgun" and unnecessary treatments), as well as the overall accuracy of the accounting function (through the billing scrutiny that NHHP was conducting). He offered that if the hospital had control of the insurance program then not only would patient care not improve, but it is likely that the insurance account would be used to clear issues outside of insurance related activities.[16]

The NHHP program had been funded for operations and reinsurance by DFID as part of a larger effort that included the insurance programs in Southwestern Uganda. The funding for DFID was to halt soon after July 2000.

Recognizing the early successes of the NHHP program, and wishing to expand to several other hospitals in Uganda, the NHHP management created (registered in July 2000) a new, completely separate Limited Company for the purposes of implementing a health financing business. This company, MicroCare, would be able to improve upon the independence that the Hospital Administrator saw as critical, while also gaining the ability to implement its product through several different hospitals. This would help to dramatically increase the risk pool, satisfy one of the greatest issues of clients – the wish for flexibility in hospital choice – and generate competition between the hospitals.

This transformation became the focus of NHHP/Microcare management and limited marketing and expansion into Phase Two. Then, once the new company was active, FU chose to delay the shifting of its clients to the new company. In a presentation at the World Bank on 6 September 2000, Till Bruett of FINCA International explained that FU's reason for the delay was due to their consideration of actually creating a FINCA International insurance affiliate in Uganda that would absorb those insured clients, as well as the risks and administrative burden that was so important to be free of in the inception of the partnership. A change of management had led to a rethinking of the approach to microinsurance.

Subsequently, MicroCare has developed arrangements with at least two other MFIs and two other hospitals in Uganda to recommence Phase Two and move on towards full roll out. This development will

[16] Explained in a conversation with Dr. Kizza A.P.M. in his office on 11 July 2000.

delay full roll out for at least another year. The FU clients continue to receive coverage from NHHP which remains within the Hospital complex managed by a new team.

VI: INSTITUTIONAL IMPACT

VI.A: HUMAN RESOURCES

The Health Financing product has had a very limited impact on FU human resources. No new staff or procedures were required.

There is no back office requirement because the group payments go directly from the insured to the insurer, and the claims are paid directly from the insurer to the hospital – FU is not involved in the financial transaction.

NHHP trains clients on the health system and logistics and conducts the initial sign-up activities. FU staff members inform clients of the product and act as feedback agents for NHHP staff during their regular Friday meetings. Basic training of the relevant credit officers (based on those working in target areas) is provided by NHHP.

In setting up and organizing the relationship, there were 2-3 weeks of activity by the credit director over a 6-month period.[17] This involved meetings with clients, staff, and NHHP management, as well as attending two general meetings conducted by NHHP, and the preparation of a product testing protocol. Unfortunately, the protocol was not followed and the data that should have been collected was not.

Even though this was clearly an NHHP product, FU should have tracked data to ensure that they were achieving their objectives. Doing this properly would have required about 20% of the time of a data clerk (who was at that time assigned to the credit director for collection of other data).

NHHP was geared up for this business and had the management and staff in place for the implementation of the product through FU. They hired, and internally trained, two nurses to manage a reception office in the Hospital.[18] In the Hospital, the two nurses were charged with identity confirmation, providing insurance slips for medications, tests and other services, assisting in-patients, and compiling detailed data on the data-base for analysis by management and for comparison against hospital bills. They also have responsibilities outside the hospital that include marketing and training client groups, and it is planned that they will provide preventive care in the future.[19]

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[17] This new Credit Director had replaced the one that was antagonistic towards insurance products for the poor.

[18] This is basically a clerical task requiring a secretary. NHHP management chose to hire nurses for several reasons:
The nurses they hire come from the training program of the hospital so that they know the other nurses and staff and thus can work more effectively with them.
They have an understanding of medical procedures and terminology, making them more suited to collecting medical data.
They have basic medical skills so that when they check on admitted patients they can confirm that they are receiving quality care.
They garner more respect from potential clients when they are marketing the program.
They are better able to provide preventive care in the groups because of their background

[19] NHHP has an incentive to reduce the costs of claims. They currently do this through a close analysis of client treatments, and a refusal to pay for shotgun and unnecessary treatments. This helped to create a new professionalism in the hospital (as related by the Hospital Administrator, Dr. Kizza). They plan to use their collected data to begin preventive health care programs outside the hospital. NHHP reports that of all insurance claims 70% and 30% (rural and urban, respectively) are related to malaria. They report a plan to distribute impregnated mosquito nets to clients to aid in the reduction of this illness. Clearly, distribution and utilization are different, so the nurses will also assist in client awareness.

VI.B: OPERATIONS AND SYSTEMS

No new operations or systems were implemented at FU as a result of the introduction of the health-financing product. The pilot testing protocol called for certain data to be collected and should have led to the development and implementation of basic tracking systems, however, this was not done.[20]

At the time of the case study visit, FU was just concluding the testing phase of their new computerized loan tracking systems. It would be relatively simple to use that system alterations to track data appropriate to this relationship, much of which is likely to be tracked anyway for internal management purposes. FU may want to consider using their new system to track the progress of objectives in the future.

Even though health care financing is not FU's business, they still recognized the need to make sure that this product, which passed through them to their clients, satisfied the needs of the company and its clients. With their new system, they could do this with relative ease and little expense, without costly assessments. If they find no benefit from the product, it is likely not worth any effort from them, however minimal. This needs to be considered in their discussions relating to the continuation or alteration of the program with their partners.

NHHP had computer systems pre-designed and managed by a computer systems professional who was also a Uganda Registered Insurance Consultant. The systems were improved several times, and as at the time of the case study visit they were awaiting a new Oracle system with better capacity to track the clients and their utilization activities.

Procedures for the in-hospital registration desk were developed to specifically address the issues of Nsambya Hospital and the FU clients. Such had been done at previous sites and will be done with future hospitals.

VI.C: FEEDBACK MECHANISMS

NHHP has several opportunities to directly interact with its clients. This happens at client group meetings where NHHP staff market the product and register clients, at the hospital when clients come for registration, and while clients are hospitalized (through the nurses visits). They also have a feedback mechanism through FU credit officers who work with the insured groups. However, though important, these are all relatively informal feedback mechanisms.

NHHP tracks renewals, and they have a detailed system for tracking and analyzing utilization (which is necessary to gather information for their actuarial calculations). Though still in the early phases of their test, they have not held any formal feedback generating meetings such as focus groups or PRA.

VI.D: MARKETING

The marketing of the Health Financing program started very strong. NHHP trained a small group of FU credit officers to introduce the product to their clients as a means of generating interest. Interested groups were visited by NHHP to provide details of the plan, visited again to assess interest, visited at least once more to register them and take photos for identification, and a fourth time to distribute the identification. At each visit the plan was discussed and promoted and questions were addressed. As some groups registered and utilized the services, their members (some with extraordinary stories of survival unlikely without the insurance, and others telling of the service from the hospital) would attend marketing sessions for new groups where they would share their stories.

[20] FU management had proposed to track several issues in order to determine the benefit to FU of the insurance product. These included: drop out rates, individual repayment rates, attendance rates, individual retention rates, cycle to cycle individual loan growth rates, repurchase rates, and group size growth by individuals.

Marketing continued at the NHHP registration office at the hospital and with the follow-up of admitted patients.

Additionally, clients from groups that were insured marketed the program strongly to clients of other groups. This created anecdotal demand for the product and the expectation that groups with the product would grow very significantly. In fact, as discussed below, there is little quantitative evidence that the product retained anyone or motivated them to join. However, adequate data collection was very weak during this period.

As the first cycle ended, NHHP management energy was diverted to planning the institutional future of NHHP (as discussed above), and marketing activities reduced dramatically. This had a severe detrimental impact in reduced renewals and limited inclusion of new groups.

VII: RESULTS

VII.A: FINANCIAL AND OPERATIONAL RESULTS

The objectives of FINCA Uganda and the results of those objectives were the following:

Table VII.A.1: FU Objectives for the NHHP/FU Health Financing Product

Original Objectives:	Results:
Increase client retention	There is no firm evidence of a direct link between the health-financing product and client retention partly due to the limited data of only two cycles and five groups. Evidence shows a net decrease of about 12% in the average net population of the five sample groups over the two cycles.
Improve individual repayment rates	For the five sample groups over the two cycles the repayment rate relationship to the insurance product was inconclusive. For three groups, repayment rate trends remained flat through the cycles, one improved by about 10%, and one declined by about 25%.
Improve attendance at group meetings	We were able to make little correlation between the product and attendance although the trends were most clear for attendance than for the other indicators. Of the five groups, four experienced 10%-20% decline in average attendance during the two cycles. One improved 30%.
Improve savings rates	Savings data for the five groups was sparse and thus no conclusions could be made. For the three groups that did report savings amounts for the two cycles of this test, savings were essentially stagnant with a slight decline of 3%. However, during this period FU was also implementing a radically new mechanism for calculating available loan amounts. This new method resulted in surplus savings for most members and nearly eliminated the requirement to save. Clients thus appear to have made decisions to maintain savings levels rather than continue to increase them. Additionally, the clients were offered the option to use savings for health scheme payments.
Increase average loan balances (and thus profitability)	As with savings, because of the new procedures at FU there is no way to determine the impact of the health-financing program on increased loan balances. Balances did grow significantly though this is most likely attributable to the policy change rather than the health scheme.

FU uses a group rating system based on attendance, borrowed amounts, and client retention to track the quality of its groups. Of the five groups in the sample, one group maintained a top rating of “A” for the two cycles, two groups maintained a “B”, one group improved from a “B” to an “A”, and one group declined from an “A” to a “B”. In general, given this small sample over a short period, there is no significant indication of any impact of the health insurance scheme on the credit activities of FU.

As for NHHP, their objectives and specific results are outlined in Table VII.A.2.

Table VII.A.2: NHHP Objectives for the NHHP/FU Health Financing Product

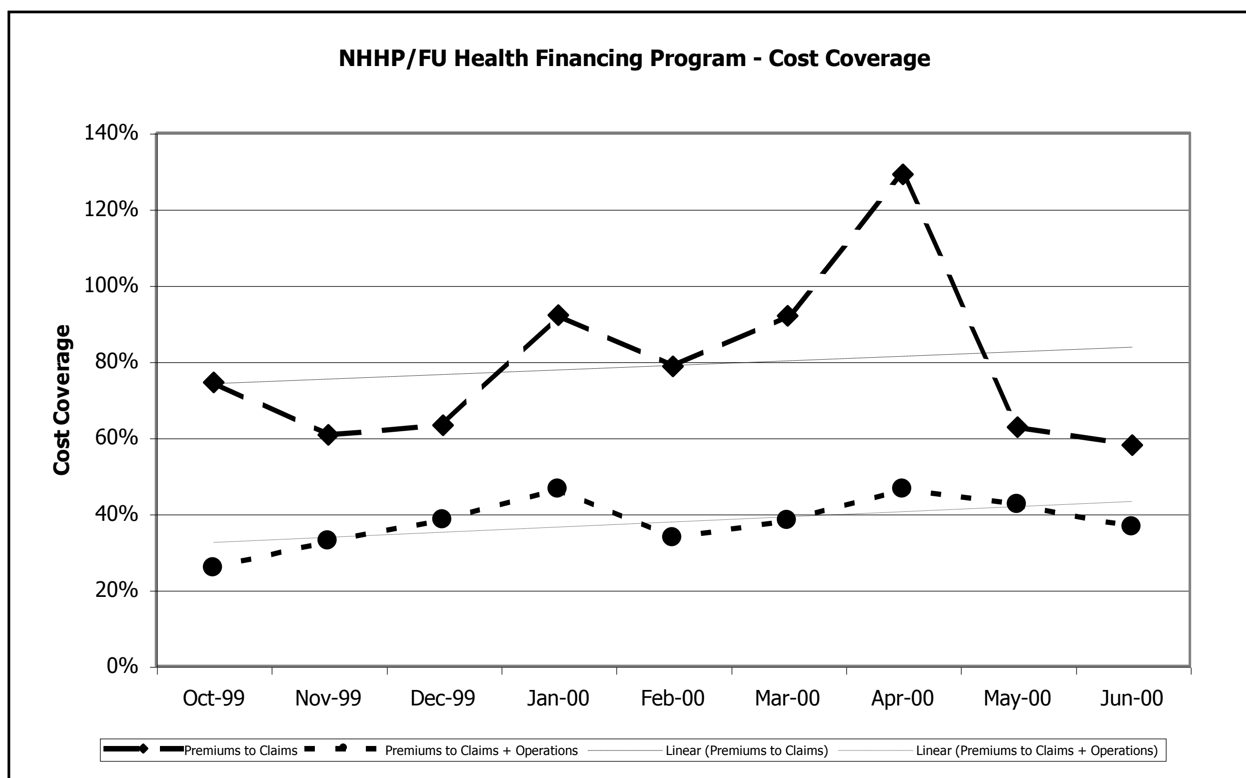
Original Objectives:	Results:
Improve client health	Though no quantitative data was gathered to assess the level of client health, responses from clients in PRA sessions were unanimous that they felt a significant improvement in the health of both themselves and their family members since joining the scheme.
Test their model	NHHP has tested their model with this delivery mechanism and have found it successful with some adjustments (noted above).
Cover all costs	Though plans from the start have called for pricing to cover costs so that this will be a surplus generating entity, this has not been the case. Coverage of claims from premiums averaged just over 60% over the first nine months of the test (75% average for the first four months and 54% average for the last five months). Coverage of operations plus claims from premiums averaged just over 30% over the first nine months (35% and 32% over the first four and next five months, respectively). Part of this problem clearly is the limited pool of insured, as well as the selection of what were most likely high utilization clients for the test, but these amounts keep the program far from sustainable and need to be addressed.
Increase the size of their risk pool	By the time of visit, NHHP had projected 1,000 families and about 6,000 insured. For various reasons, they were servicing 149 clients with 625 total insured.

Table VII.A.3 provides detail of the financial results of the NHHP/FU health-financing scheme for the period October 1999 through June 2000. Although the cost coverage rates are variable, the trend line is slowly increasing relative to claims coverage alone as well as the total cost of claims plus operations.

Over the last two months covered by the data there is a sharp decline in cost coverage. Although this coincides with the introduction of three new groups to the program, the decline is substantially related to increased usage by existing groups. Existing groups covered only 50% of their claims from premiums in May/June versus new groups covering 84% of their claims through premiums in the same period. During the March/April period existing groups covered 109% of claims from premiums. The specific reasons for this relative increase in claims requires additional research.

Most of the operations costs are fixed and should thus reduce relative to overall costs as the program grows. However, the current deficiencies are troubling. These deficiencies have historically been covered by DFID, though that relationship will end. This Table indicates how critical it was for proper implementation of the premium increase that should have taken effect in February 2000. An additional 30% in premiums likely would have allowed for full coverage of claims until the decline in May which would have been mitigated.

Table VII.A.3: NHHP/FU Cost Coverage



(Source data for above table are NHHP internal records, calculations by the author.)

Given that the duration of the test has been short, a mere 9 months, and the initial clients were chosen specifically because they were expected to utilize the system more than an average insured would (due to geography and testing the new system), utilization by clients is expected to decline over time. However, there is a clear need to re-assess the cost and premium structure of this product. The next section, Client Perspectives on the Product, looks at utilization in greater detail.

Nsambya Hospital reports reasonable satisfaction with having reached its objectives in the plan.

Table VII.A.4: Nsambya Hospital Objectives for the NHHP/FU Health Financing Product

Original Objectives:	Results:
Gain access to new patients	The administration of the hospital is clearly pleased with the influx of new patients to the hospital (those who would have gone to clinics or other facilities). They did expect larger numbers of new clients but have hopes that those will come.
Reduce collection burden	The administration stated satisfaction with improvement in the collection system by aggregating the bills and submitting them to one payor. They do this with others, and want to have as many such payors as possible.
Improve profitability	The administration believes that by virtue of new patients buying services priced properly they will improve profitability. However, there is no evidence of this at this point.
Provide a health funding mechanism for periodic workers	Their specific objective to access seasonal workers is not considered satisfied and management does not believe this will be satisfied through working with MFIs. Management has discussed other mechanisms for providing access to these potential clients.

VII.B CLIENT PERSPECTIVES ON THE PRODUCT

Prior to coverage under the NHHP policy, clients reported several strategies for addressing medical care. Among these are:

- ⇨ Visiting the nearest local clinic, many of which are unsupervised and operated by people with questionable credentials
- ⇨ Self-medication through purchasing over-the-counter drugs and/or prescription drugs from the numerous unsupervised (and often illegal) drug shops operated as microbusinesses
- ⇨ Bought or grew their own herbs for traditional self-medication

Clients perceive that these various strategies are cheaper than proper medical care at a top quality medical facility. Finding the money to pay for medical care of any sort is difficult. Some prior strategies of these clients to fund medical care included:

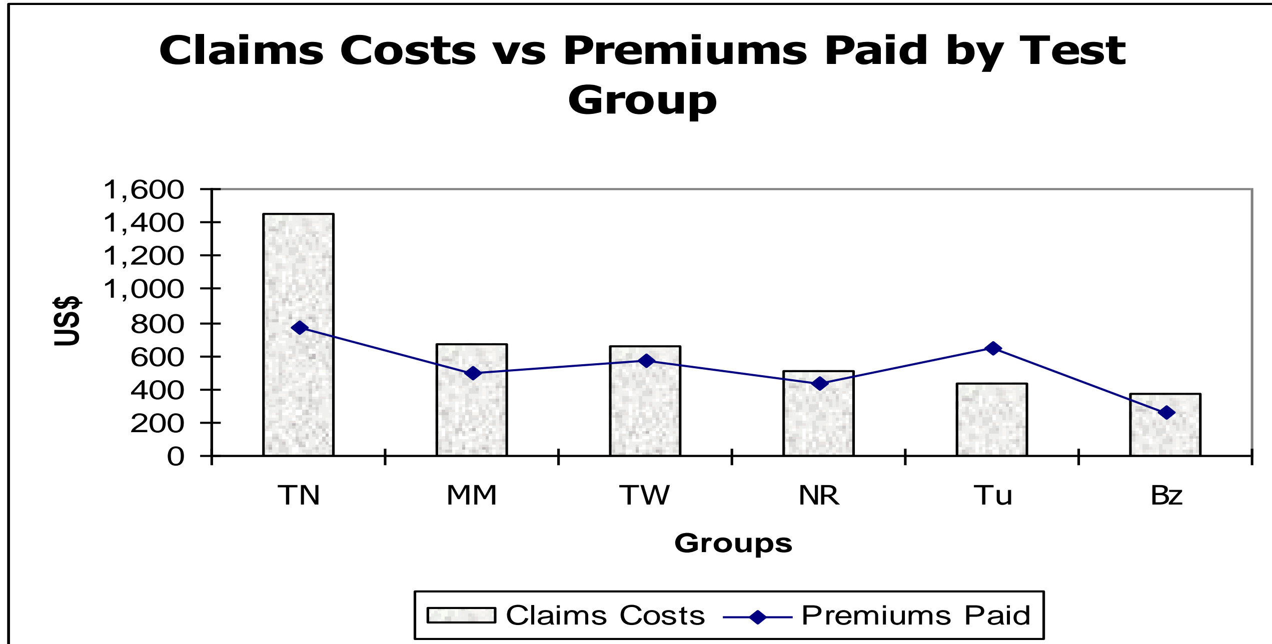
- ⇨ Postponing treatment until the illness became such an emergency that they risked death if they waited any longer.
- ⇨ Obtaining medical attention from drug shops, traditional healers, and local clinics on expensive credit
- ⇨ Seeking loans from friends and relatives – these are reported to be increasingly more difficult to acquire.
- ⇨ Pawning or selling assets to finance healthcare – this is especially true if the patient was admitted and cannot be released from the hospital because of outstanding bills.

Illness often creates a downward financial spiral in a household, where ineffective measures are used and paid for until the illness becomes a crisis and the patient requires hospitalization. With hospitalization, the patient then needs continuous care, usually by the mother/wife/daughter. The family experiences a liquidation of any available resources, climbing debt, and a reduced ability to earn money since the woman is not at her business. Business assets are then often sold to generate the needed funds to pay the medical bills. This cycle often returns improving households to poverty.

The health-financing scheme has therefore promoted visiting the hospital as soon as one is unwell to minimize the losses to the client and the cost to the plan. NHHP has also taken an approach of covering the total cost of care (less the small co-payment and transport). This has resulted in significant utilization of the services. The table below details the claims costs by test group for the nine months of the test, and plots that against the premiums paid by each client group.

Table VII.B.1 shows that except for one group, the groups are utilizing more services than they are funding. Clients, at least those who are using the services, are getting a good deal with this product. Although this is not likely to continue, maybe this helps in understanding why several clients commented that the insurance is "cheap" compared to their prior strategies.

Table VII.B.1: Claims Costs vs. Premiums Paid

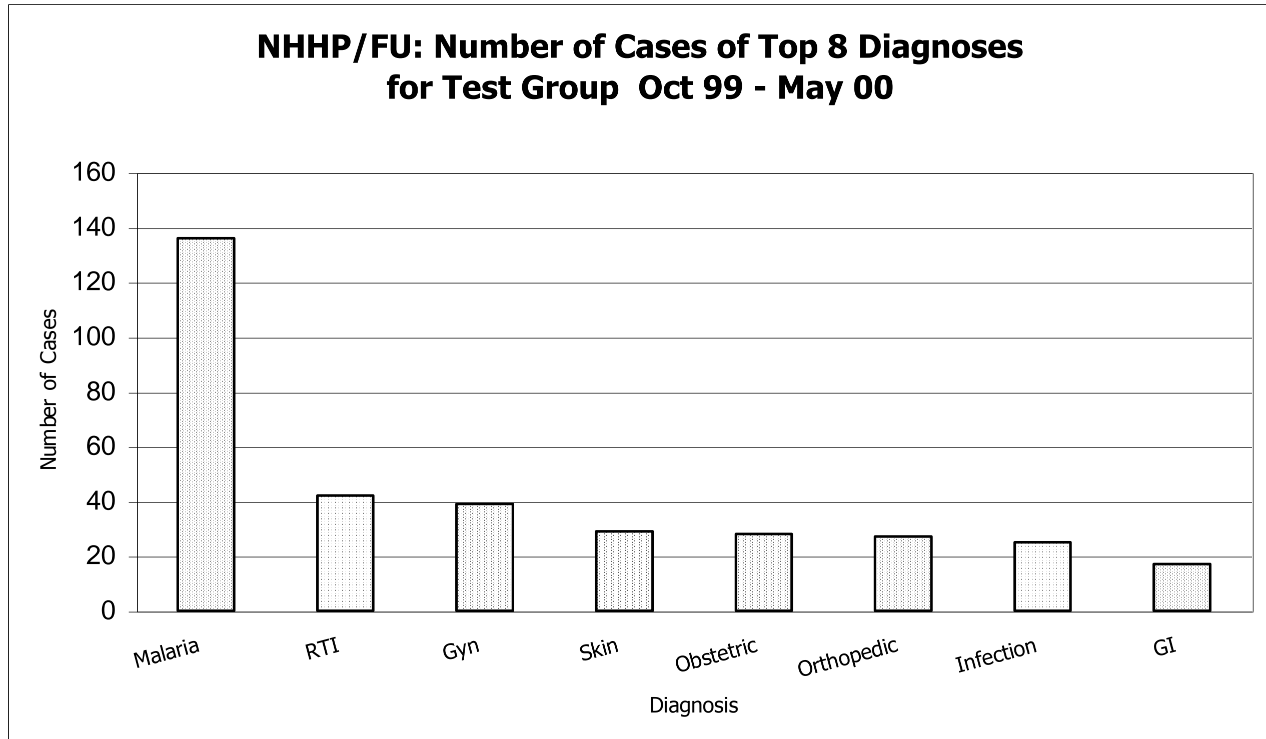


In order to adjust the cost to cover these claims expenses and the operational costs noted above, it is clear that NHHP will need a combination of several strategies to generate a surplus. These include: re-assessing the premiums and the coverage, as well as the operational cost structure. Significant expansion of the insured pool should help.[21] Additionally, NHHP has a strong incentive to promote preventive care to reduce the incidence of illness.

NHHP has found that in Kampala, the most frequent cause of hospital visits by insured clients is malaria. Malaria occurs three times as frequently as the next most frequent occurring illness, respiratory tract infections. Table VII.B.2 shows the top eight most frequent diagnoses over the nine months of the test.

[21] It is important to note here again that the initial clients were selected near the hospital with the knowledge that their utilization would be higher than an "average" insured client, thus the proportion of covered costs is likely to increase as the risk pool expends. In addition, it was fully anticipated that at least the first cycle for each group would be expensive as clients tried out the system and cared for pre-existing conditions.

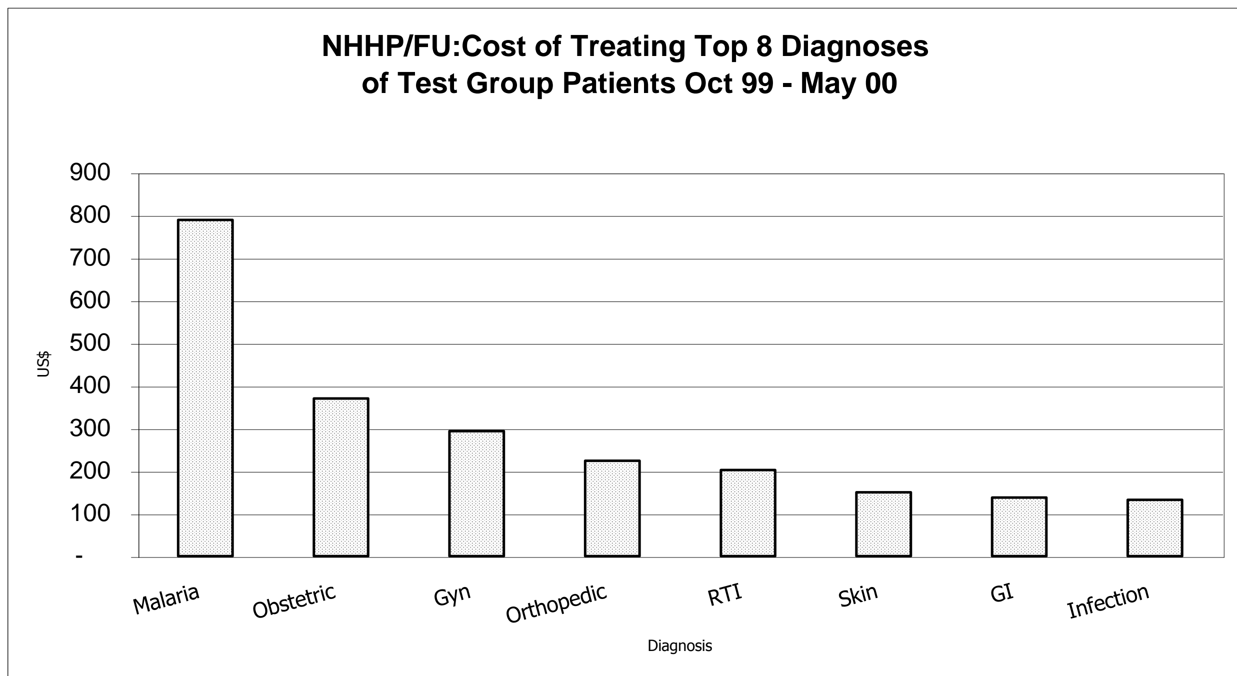
Table VII.B.2: Top Diagnoses



(Source: NHHP data)

The total cost of treating these illnesses is shown in the next chart, below.

Table VII.B.3: Cost of Treating Top 8 Diagnoses



(Source: NHHP data)

These numbers have pushed NHHP to look for ways to address the high cost of treating its insured for malaria. Their discussions have included the provision of bed nets impregnated with insecticide to insured families providing some protection when people are most vulnerable to contracting malaria.

The issue of preventive care by the insurer is a critical one. We see in this relationship that the insurer has incentive to provide benefits to the insured to minimize the frequency of their illnesses, not just treat them when they are sick.

Clients say they find this insurance helpful, and many of them use it frequently. It had been expected that with such a positive response that clients would have stayed in the health-financing program, and that new clients would clamor to get into groups offering the product. FU staff provided anecdotal evidence to support this expectation.

Contrary to the anecdotal evidence, there was significant dropout from the program and limited new entry between the first and second cycles. Again, this is early in the test and there could have been several exogenous factors for these results.

Table VII.B.4 shows client population activity between the first and second cycle of this test. Clients in this case are premium-paying clients of NHHP.

Table VII.B.4: Client Selection Activity

NHHP / FU C1 to C2 Client Activity

Group	Cycle 1 10/99-1/00 # Clients	Drop outs End of C1	New For C2	Cycle 2 1/00-5/00 # Clients
TN	24	11	10	23
Tu	24	13	4	15
TW	18	6	4	16
MM	19	10	8	13
NR	17	3	2	16
Bz**	20	20	-	-
Totals	122	63	28	83
Kg*				18
NaA*				22
NaB*				26
Totals				149

* Entered new in cycle two
** Returned for third cycle
Source: NHHP and FU internal documents

Over half of the insured in the first cycle did not go on to the second. One-third of these were from a group that completely dropped out for the second cycle and then re-entered the program in the third cycle. Even excluding this group there was a 42% drop out in one cycle. This suggests an attrition rate of over 120% per year! New clients to the original groups only replaced about half of the dropouts. Thus, the net change in population from Cycle One to Cycle Two was a decrease of over 30% (or 19% if Bz is excluded). In order to retain some of the groups, NHHP had to suspend its rule that 60% of the group had to join the scheme, thus increasing their risk.

Several issues are apparent in this trend.

- Several clients who did not acquire illnesses during the cycle noted that they did not get any value from their premium, while they watched several other group members acquire extensive services. This is related to the difficulty of getting people to understand the idea of pooling, a concept critical to an understanding of insurance. Several of these clients simply did not pay the renewal premium. These people also noted the cost of the product for which they did not recognize any benefit. Some training and marketing might have been helpful in these cases.
- It is clear from some of the details of care that several clients were insured in the first cycle so that they could get treated for pre-existing conditions. Once these were covered, they may have seen no additional need of the product and did not renew.
- Anecdotally, the option for clients to use their savings accumulated through weekly savings as part of FU (to pay their health financing premium) was little used. FU calculates available amounts for loans based on the savings of the clients. More savings yields a larger loan. This made clients wary of using their savings for the health scheme.

  FU management offered to consider savings spent on insurance as part of the available loan calculation. However, again anecdotally, credit officers refused to offer that option to their clients. (Credit officers are paid an incentive for, among other things, portfolio quality and did not want to reduce their leverage for the sake of a product for which they received no commission.[22])
- Initially, marketing efforts were strong, but declined on the part of NHHP as management focused on internal institutionalization issues. FU staff played little role in the marketing during the first cycle and thus did not market significantly in the second. Marketing was understood by FU staff to be the primary responsibility of NHHP.

The objectives of the hospital and NHHP were substantially satisfied. While almost all institutional objectives of FU were unmet. Many of the trends – client dropouts, stagnant financial results – suggest the need for a re-assessment of this product both in terms of client responses and the cost/price mix to promote a healthier health care financing product. FU should reassess the product in terms of its overall institutional value.

VII.C: CORPORATE CULTURE

The health-financing business was still a new for FU during the case study visit. Its impact on the corporate culture had been minimal. Only five credit officers (out of more than 45), the credit director, training coordinator, and the country director were involved in the relationship with NHHP. Even the supervisor of the credit officers had not been involved. This activity was simply the result of the continuation of the innovative corporate culture that was being promoted at FU. It is expected that once this test is expanded to provide access to more clients, it will have a greater impact on the corporate culture.

One way that it has influenced the larger corporate culture of FINCA International (FU's parent) is that it has shown them a new business with high potential to assist the poor. They are thus considering insurance business as a potential addition to their credit business. Wisely, they have chosen not to become health insurers at this point, but report that they will watch the progress of the current test and improve their overall data collection and review of the relationship and benefits to the company and its clients.

[22] Commission had been offered towards the end of the first cycle to credit officers but the offer got to credit officers in a confused manner and then was not paid. This resulted in some antagonism towards the product by the credit officers. This may also be a reason for the high level of drop out.

VII.D: PRODUCT DEVELOPMENT PROCESS

The product development process in this case was almost entirely driven by the NHHP management. They had objectives of growth, utilization, and cost coverage, and closely tracked that data. They had a multiphase plan for the introduction, buildup, and rollout of the product. They tested the basic product concept in Southwestern Uganda and adapted it for use in Kampala with MFI clients.

FU improved on its product development from the GPA policy by actively participating in discussions with NHHP management about the adaptations required for urban MFI clients. They developed a protocol with specific objectives, targets, reporting activities, and decision points. However, they did not follow their protocol and were left with very limited data when it came time to analyze the test phase for indicators that were relevant to their objectives.

VIII: SUMMARY OF LESSONS LEARNED

The research on the Partner-Agent model as illustrated in FU's relationship with NHHP has revealed much interesting and enlightening information. In general, the Partner-Agent model has allowed for new business development in ways that reduced risk to the MFI, and offered innovative insurance products to MFI clients.

There is much to be learned from the experiences documented here. These are summarized below in bulleted points. A further summary can be found in the tables at the end of the document.

- There was no evidence of any impact from the health care financing of clients on the credit activities of FU.
- Developing and following a protocol for testing any new product is essential to the product development process.
- Insurance is a difficult concept for staff to understand and feel confidence in order to sell it. Thus, training needs to be provided using several different techniques. Staff should be tested on their understanding, and have easy resources to refer to when addressing clients.
- Although there were clearly significant problems with the provision of health insurance, at least the financial risk fell to an institution other than the MFI.
- Premium prices must be structured to cover costs from the start. Increases in the price are difficult for clients to accept, while reductions are highly palatable.
- When donors are involved in funding an insurance program such as NHHP, there can be a temptation for the insurer to respond slowly to needed adjustments in the price simply because a donor will cover the losses. This can also be a detrimental factor in the initial pricing of the product where prices are set lower simply because a donor will fund the losses.
- It is important to have a savings mechanism available for clients to save for the periodic premium, though other factors might keep them from utilizing it. Such factors with FU include client reluctance to use their savings thinking that this might reduce their next loan value, or credit officers not wanting to lose their leverage on borrowers.
- Marketing has to be consistent. When it dropped off in this program, client volumes fell dramatically. Though this is not only reason for the high attrition, several of the main reasons were education related, and these could have been addressed with strong marketing.
- An MFI needs a simple system to track information relevant to the institutional objectives of the product. FU's lack of this made decision making more difficult.
- Segregation of the insurer from the hospital provides an important quality control function over the hospital.

- A Partner-Agent structure places the incentive for preventive care on the insurer partner.
- Although still in the early stages, it is clear that having an external health care financing program coupled with an MFI results in important synergies that provide great potential for the improved access to quality health care by the poor.
- Many of the problems experienced in the test thus far have been related to the programmatic nature of NHHP. Although several of these issues will be dealt with in the new Microcare structure, it is still preferable to work with regulated insurers (depending on the insurer) where possible. This satisfies issues of reserves, capacity, and oversight that are important for the provision of insurance.
- This case also makes it clear that for reasons of choice and risk pool volumes, these efforts should move beyond both a single hospital and a single MFI. This suggests the strong preference for a non-MFI insurer who will be able to negotiate and manage the multiple relationships and increasing risks, as well as spread their programs more broadly (where an MFI would not offer its products to other MFIs).

Table VIII.1 outlines the specific strategies used by both FU and NHHP to reduce risk inherent in these insurance products.
Table VIII.2 summarizes the strengths, weaknesses, threats, and opportunities by stakeholder. This information can be utilized in product improvement, and in new product development by other MFIs.

Table VIII.1: Managing Insurance Risks: The Strategies used in the NHHP/FU Provision of Health Financing

Risk:	General Strategy:	Specific Strategy:
Moral Hazard	Pre-selected providers	Works only with Nsambya Hospital, two pre-assessed pharmacies, and two dental clinics
	Claims limits	Limit claims per cycle to $233
		Limit inpatient time to three weeks in one cycle
	Co-Payments	Co-payment for business hours out-patient care ($0.66), after hours out-patient care ($1.00), and in-patient care ($1.33)
	Coverage restrictions	Will not cover "shotgun" or excessive treatments (insurer does not pay hospital for these)
	Loss review	Detailed review of claims for cost and treatment
		Review includes assessment of treatment habits of individual doctors.
	Exclusions	Direct exclusions include intentional injury, long-term medications, and willful participation in acts of war.
	Waiting periods	No waiting periods. Insurer recognizes this market will have preexisting conditions and wants insured to have them addressed as soon as possible.
	Proof of event	Insured must get preapproval at NHHP registration desk before incurring claims costs.
	Client identification	Laminated identification cards provided to each client.
		Family photo required to identify non-client insured
		Client and family photo digitized and accessible on computer so that at registration with NHHP patient ID is visually confirmed.
	Pre-approval of treatment	Insured must be identified and receive billing sheet from NHHP registration nurse prior to receiving any insured treatment
	Expenses verification	Monthly case by case verification of expenses
	Clinical treatment verification	Monthly case-by-case verification of clinical treatment conducted by in-house physician.
		Frivolous treatment not covered and has reduced such 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 FU clientele
Adverse Selection	Membership from existing groups only	Insured are drawn from existing FU clientele
	Whole family membership required	Require client plus three, and then one at a time can join at a separate price for adults and children. Flexibility of who gets added increases risk
		Whole family membership (beyond client + three) is not required. Potentially increases risk.

Risk:	General Strategy:	Specific Strategy:
	Required membership within groups	Stated policy is that at least 60% of group members must be insured for NHHP to work with the group. In practice, this was not followed after the first cycle.
	Defined risk pools	Defined as microbusinesswomen and families. No separation for business activity or other differential risk factors.
		Adults and children are priced differently with adults considered at higher risk.
	Waiting periods	Clients can only join insurance program at the start of a FU loan cycle (every four months) and would have had to be at least saving with FU for at least four weeks in order to borrow from them.
	Tying insurance to other products	Insurance is tied to the FU loan product
Cost escalation	Periodic cost evaluation	Conducted monthly during claims review, though insurer has little power to adjust prices (until the volume of clientele increases).
		Soon will work with other hospitals and the cost evaluation will include cost comparisons between hospitals.
		Four month insurance cycle limits potential loss due to unexpected price escalation and allows for price adjustment
	Preset pricing agreements with providers	No such agreements with this product
	Preset drugs list	No preset drug list with this product
Fraud and Abuse	Co-payments	Co-payment for business hours out-patient care ($0.66), after hours out-patient care ($1.00), and in-patient care ($1.33)
	Computerized ID systems	Photo ID with client and digitized and available at registration
	Coverage limits	Period of in-patient stay and

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

NHHP - FINCA Uganda Heath Financing Product **Strengths, Weaknesses, Threats and Opportunities by Stakeholder** **STRENGTHS of the program with regards to each stakeholder**			
Insurer	**MFI**	**Hospital**	**Clients**
Strong controls at client level	Virtually no risk to the MFI	Stable pool of "new" clients	Clients report significantly improved health.
Systems minimize potential for moral hazard	Very limited administrative burden required of the MFI	Potential for reduced defaults	Efficient mechanism available to save for premium payments
System minimizes adverse selection through use of MFI and imposing 60% minimum	Competitive advantage as sole MFI offering a health insurance financing product	Currently hold monopoly on the clients participating in this product	Policy is "cheaper" than previous healthcare (self) financing.
Minimizes costs of marketing and premium collection through the use of MFI	Improved health of clients and families should result in improved borrower performance (not evidenced yet but test is in early phase)		Incentive is with insurer to provide preventive and wellness options, and thus, because they want to save money, these are more likely to be provided.
Clients use scheme to get treatment for illnesses as soon as they become evident, reducing need and cost of treatment of a more entrenched illness.	Partner relationship allows MFI to offer a complex product, reducing risk to the MFI.		Convenient. Clients use scheme for illnesses as soon as they become evident, reducing need and cost of treatment of a more entrenched illness.
Co-Payment requirement minimizes unnecessary use with limited disincentive for legitimate use	Strong client understanding of the differentiation between MFI and Insurer product		Care improving as insurer reduces hospital shotgun cures and over treatment.
			Third-party payments. Claims are paid directly to the hospital, thus client only pays transport, and co-payment from liquid funds and awaits no reimbursement. The insurer pays the total costs directly to hospital.

Table VIII.2, Continued

WEAKNESSES of the program with regards to each stake holder			
Insurer	**MFI**	**Hospital**	**Clients**
Frequent renewal periods enhance potential for moral hazard	Limited client understanding of risk pooling	Hospital cashiers are rude to clients	Limited client understanding of risk pooling
Confusion for clients at the check-in desk during nights, weekends, and public holidays when check in nurses are not available.	Pilot test plan developed but not followed leading to significant difficulty determining the success of the test from the perspective of the MFI.	Hospital has had problems with accurate billing	Appears to be some adverse selection partly due to the short renewal periods, and the lack of restrictions on pre-existing conditions.
Weaker controls at cost confirmation, due to difficulty obtaining full and updated pricing lists for procedures and drugs from the hospital	Requirement that clients must be borrowers restricts use and potentially promotes unnecessary borrowing.	Treatment has occasionally been through shotgun cures, and over treatment (this is improving)	
Limited client understanding of risk pooling			
Lack of formal reserves			
Limitation of one hospital creates problems re: competition, client geography, and religious issues			
Lack of written policies and formal notifications to clients			
Not currently sustainable and price adjustment to improve that was not communicated to clients, nor was it enforced			
Limited formal pilot test plan			
The financial position of the insurer is precarious and highly dependent on donors at this time.			
No requirement for full family increases adverse selection potential			

Table VIII.2, Continued

THREATS of the program with regards to each stake holder			
Insurer	**MFI**	**Hospital**	**Clients**
Legality is in question with weak laws in Uganda. Required to term this a "health financing scheme" and not "insurance"	Currently scheme is exclusive to FINCA, soon they will lose their competitive advantage when Insurer spreads to other MFIs	Expansion of scheme to other hospitals (planned "soon") will eliminate exclusive rights to clients and promote competition	Weakness of reserves structure of the insurer puts clients premiums at risk
Management is dependant on one leader and two technical staff. Loss of any of them would be highly detrimental.	MFI is reliant on insurer for continued services to its clients.		
No formal agreements with MFI. THUS, MFI could leave with their clients at any time. With only one MFI as a partner, this presents a large threat.			
Though data collection has been very strong in this program, the Excel database that is used to collect data will quickly run out of capacity.			

Table VIII.2, Continued

OPPORTUNITIES of the program with regards to each stake holder			
Insurer	**MFI**	**Hospital**	**Clients**
New insurance law (likely to include "Community Health Allowances")	Likely, discount from insurer compared to new MFIs based on FU's Research and Development role with the product.	Significant excess capacity exists at the hospital	Future options to access other hospitals
Use the lessons learned with MFI to market to other MFIs			When program expands to other hospitals, competition among them should improve care.