"Creating partnerships to insure the World's Poor"

International Centre for Development and Research (CIDR-Uganda)

Community Based Health Prepayment Programme Luweero, Uganda

Notes from a visit 24-25 June 2002

(Research conducted for ***MicroSave***)

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INTRODUCTION AND BACKGROUND:[1]

In 1999, the International Centre for Development and Research (CIDR), a France-based NGO, decided to test its reportedly successful mutual microfinance methodology in East Africa and conducted a study mission to Kenya, Uganda, and Tanzania. These studies assessed the potential of their methodology in terms of economic, social, and institutional characteristics that CIDR deems necessary for the success of their program. The results (plus the availability of donor funding) led CIDR to Luweero District in Uganda. In retrospect, CIDR management has noted that although the institutional and economic aspects were sufficient (in terms of the hospital partner and the poverty level of the residents), the social aspects were very weak.[2]

Implementation of the program began in 2000 with an initial four villages, developing services to fund access to the Kiwoko hospital[3]. The initial growth strategy was to identify villages in areas that differed significantly in order to provide a variable sample for later research. Thus, the first four associations were located: 1) close to the hospital, 2) in a distant pastoral area, 3) far from the hospital (over 60 kms), and 4) at an intermediate distance. Subsequent growth was focused on new villages near the original four, based on the expectation (which the annual reports note turned out to be false) that participants in the project villages would generate the interest of those in nearby villages.

This village-based program uses a mutual insurance model that has as its objective complete "ownership" of the activities by the members. CIDR-Uganda management defines "ownership" in this case as "a feeling of people that they manage and make all the decisions for the scheme. That they know the scheme is theirs." CIDR-France has concluded that such "ownership" and the resulting autonomy are not likely to happen with this project within the next ten years. It thus no longer warrants (per CIDR policies) an expatriate manager after the first three-year phase. CIDR is now transferring project management to a newly created NGO (while retaining the same staff and members) called *Save for Health Uganda*, under local management and with some oversight by CIDR France.

Kiwoko Hospital has been the project health care provider since the beginning of the program. Kiwoko is a high quality medical facility, specializing in health care in the rural areas. The CIDR program covers only in-patient (and emergency out-patient dental) care. Out-patient care must be funded from other sources.

CIDR currently works with seven active associations with a total of 837 members. Membership is open to all residents of a village where CIDR is working, and these villages are clearly low-income areas with many residents who must rely on coffee sales for income. Such sales have diminished in recent years due to falling international coffee prices and a problem with "coffee wilt" which reduces plant yields.

Currently CIDR has no significant competition for its program.

[1] The authors wish to thank the senior management of the CIDR Uganda program, Elodie Yard and Fredrick Makaire, as well a their staff, the project related personnel at Kiwoko Hospital, and those members we visited. All of these people were extremely helpful in compiling the data for this visit.

[2] Luweero District was severely affected by the "bush war" that brought the current government to power in Uganda in the late 1980's. This had at least two results impacting this program: (1) very many give-away projects were provided for the people, leading to an expectation of free goods and services, and (2) several different ethnic groups have settled in the area leading to difficulty in developing group ownership. Both of these issues have caused significant problems for other sustainability-minded NGOs in that area.

[3] Kiwoko hospital is a full service, two hundred bed, private mission hospital. They are located outside Luweero Town approximately eighteen kilometres (on a murram road) from the main North-South highway in Uganda.

CIDR'S COMMUNITY BASED HEALTH PREPAYMENT PRODUCTS

In keeping with the objective of full ownership of the product by the members, members technically design the products. CIDR, however, does provide a basic product guideline and in practice this is what members choose, thus there is little variation in product composition between associations. That said, some variation has emerged in a few associations in response to particular association issues with the product. This adaptation appears to have occurred over time and is based upon experience with the product by these associations.

CIDR associations currently offer one of two health care financing options: a mutual insurance product and a health credit product. Some associations offer both options and one of the credit associations also allows for out-patient loans. The insurance option requires members to pay a set premium annually to receive care paid for by their association within the limits of the agreed policy. The credit option requires a single capitalisation payment upon commencing membership and subsequent annual payments cover the minimal operating costs of the association. This allows for members to obtain a loan (paid directly to the hospital) when in-patient care is provided at the hospital. The loan is then to be repaid over a three-month period *without* interest.

PRODUCT	
Eligibility Criteria	▪ All households within a village that is part of the program are eligible to join. All members of the household ("living under one roof") must join if the household joins, though CIDR has found this difficult to police. ▪ Insurance associations must have a minimum of 100 individual members. ▪ Credit associations must have at least 80 individual members ▪ The above two requirements have been frequently circumvented in order to generate associations.
Coverage	▪ Covers in-patient care and emergency dental care only provided at Kiwoko Hospital
Duration of Cover	▪ One year
Limitations	▪ In general, chronic diseases are covered 50% with an annual ceiling of Ushs 50,000 (US$28)[4] ▪ Some schemes set a single general cap (of Ushs80,000 to 100,000 or US$44-$56) per admission for any event including chronic illness. ▪ Only one episode of hospitalisation will be covered per person per year ▪ With the credit option, only one outstanding loan per person will be allowed at any time.
Exclusions	▪ Out-patient care, alcoholism- related incidents, elective surgery, self-inflicted injuries, and dental plates. ▪ Any care provided outside Kiwoko Hospital
Mode of Delivery	▪ Health care is delivered at Kiwoko Hospital. ▪ Insurance is delivered through village associations, and their sub-associations called "social associations." ▪ CIDR Uganda provides extensive technical assistance to the associations.
PRICING	

[4] At the time of the visit, the exchange rate was Ushs 1,800 to US$1.

Premium	▪ Each association sets an agreed upon premium for the (insurance or credit) product it selects. This process is conducted with significant input from CIDR. This assistance is reflected in the common premium of Ushs 3,600 (US$2.00) per person per year that is charged by almost all associations. ▪ Some associations do use a tiered approach to limit the difficulty to larger families joining. This structure is: • Ushs 3,700 (US$2.10) each for the first four family members • Ushs 3,400 (US$1.90) each for the next five family members • Ushs 3,100 (US$1.70) each for all subsequent family members
Method of payment	▪ The social group treasurer collects premiums from individual families any time during the three months before the start of the insurance term (though they find that most payments are made immediately prior to the start of the term). The social group treasurer presents the collected funds periodically to the association treasurer, who accumulates the funds and deposits them with the prepayment cashier[5] at the hospital. On a daily basis (when necessary) the funds are transferred to the Hospital Chief Financial Controller who holds them in safekeeping at the hospital, as collateral. The hospital provides monthly statements to each association with funds held there. ▪ Each month when claims for health care services at the hospital are due for settlement, the prepayment cashier travels to meet with each association's Management Board in order to reconcile the billing with the records of the association. At the end of this meeting the association leaders sign a "monthly invoice" with its attached "paying slip" authorizing the prepayment cashier to make the payment in full from the association's funds held at the hospital. Thus, settlement is effectively immediate.
Other	▪ The credit product of the CIDR programme is funded through a refundable capitalisation payment (rather than a premium) of Ushs3,600 (US$2.00). This amount for each member of each family comprises the capital base of the loan fund. Members also pay an annual management fee to cover operational expenses of the association and social groups. The value of the capital payment was set as equivalent to the annual premium of the insurance scheme because CIDR did not want initial costs to determine which program the association joined. ▪ The credit product is offered at a stated zero percent interest rate for three months. However, the association receives a 10% discount from the hospital that is not conveyed to the borrower. The borrower repays the full amount of the care and thus effectively pays interest of about 11% on the funds actually borrowed.
Co-payments	▪ Co-payments are applied at 50% for some associations in an effort to curb the overuse that led to rapid depletion of association capital in the insurance associations. ▪ Some associations charge set co-payments of between Ushs 2,000 and 5,000 (US$1.10 and 2.80) for each time the insurance is accessed.

[5] The "prepayment cashier" is stationed in the same office as the hospital cashiers, but was originally hired by the hospital and CIDR to conduct all CIDR prepaid insurance transactions. For nearly the first year CIDR paid the salary of the prepayment cashier who is now fully funded by the Hospital.

Premium/Capitalisation fund structure	▪ The funds are divided into four (or in two cases five) components by CIDR after the final payments of the loan term are paid for each association. The general distribution of fully paid premiums is:
	  ▪ 70% "Treatment" or "Revolving" fund depending on the association type
	  ▪ 18% Management Fund
	  ▪ 12% Security Fund (reserve - only accessed upon association vote)
	  ▪ The "Frozen Fund" which holds the balance of incomplete premium payments but cannot be used by the association until the premium payment is complete.
	▪ Two schemes use a mixed credit and insurance structure where the first Ushs30,000 (US$17) of the health care cost is credit and subsequent amounts are covered by insurance. These associations split their Treatment / Revolving Fund allocation into two pieces: the "Treatment Fund" (30% of the fund or 21% of the total premium), and the "Credit Fund" (70% of the fund or 49% of the total premium).

Discounts	▪ The hospital offers a 10% discount on care of association members. This started at 5%, and then went to 7.5%, and finally 10% after negotiations by beneficiaries during the regular bi-annual meetings between each association and the hospital. ▪ The hospital has also agreed during these negotiations that they would increase the discount to 12.5% for associations with at least 200 members. ▪ Insurance and credit associations transfer the discount from the insurance or revolving fund to their frozen fund and decide how to use the accumulated amount during the general meetings. With the insurance product, this has the effect of decapitalising the treatment fund because they actually transfer the discount from the treatment fund to the frozen fund for non-insurance related activities. For the credit product, because the debtor repays the gross cost of the treatment, this effectively imposes an interest rate on the loan to the member of approximately 11% for a three-month loan.
PLACE	
	▪ Insurance business is transacted with member associations in their villages and sub-villages. ▪ Bulk premium transactions occur at the hospital ▪ Claims transactions occur in the village. ▪ Care is provided at Kiwoko Hospital, the most comprehensive health care facility in Luweero and neighbouring districts (other than Kampala). This hospital is a long distance from most of the associations. At one association in the near geographical centre of the CIDR market, beneficiaries pay Ushs 3,000 (US$2) round trip from home to the hospital. This greatly increases the cost of care to the beneficiaries, especially when it must be doubled to cover the cost of a caretaker.
PROCESS	
Enrolment/Renewal	▪ Enrolment and renewal take place in the local village between the household representative and the social group treasurer. ▪ Three months are provided to make partial payments to build to a full premium payment.

<table>
<tr><td>Receipt of Treatment</td><td>▪ Members have a special window to register at the hospital as part of the scheme, the rest of their treatment is supposed to be conducted without the doctor's knowledge as a control strategy (however, we were informed that in practice the doctor often does know the membership status of patients).
▪ For most members, the cost of transport to the hospital is rather high. There is a plan to effectively equalise the total cost of the co-payment / transport sum for all members.
▪ Because the coverage (except with one association) only includes in-patient care, the members face the very real risk of being sent home after seeing the doctor because they are not deemed sick enough to be admitted. This results in members paying for transport, consultation, and any tests and medications out of their personal funds. The hospital costs are significantly greater than those at local clinics. Often people will first go to the local clinic to determine if they are sick enough for admission, but occasionally they get admitted to the clinic and then get no benefit from their CIDR membership. It was estimated by the prepayment cashier that only one of every three attempts to gain admission are "successful."
▪ The process of obtaining treatment at the hospital is outlined in Appendix 3: Patient Flow at Hospital.</td></tr>
<tr><td colspan="2">PHYSICAL EVIDENCE</td></tr>
<tr><td></td><td>▪ Beneficiary households receive a Membership Card. This notes the association, social group, and family particulars. They also have space for a single photo of the family and provide a summary of the policy on the back for easy reference.</td></tr>
<tr><td colspan="2">PEOPLE</td></tr>
<tr><td></td><td>▪ Their own elected leaders guide their associations.
▪ The prepayment cashier was described as helpful, but there have been problems with other cashiers, though this is said to have cleared up.
▪ CIDR has field agents frequently working with the members</td></tr>
<tr><td colspan="2">PROMOTION</td></tr>
<tr><td></td><td>▪ Extensive sensitisation by CIDR
▪ Road shows
▪ Promotion by local leaders
▪ Posters</td></tr>
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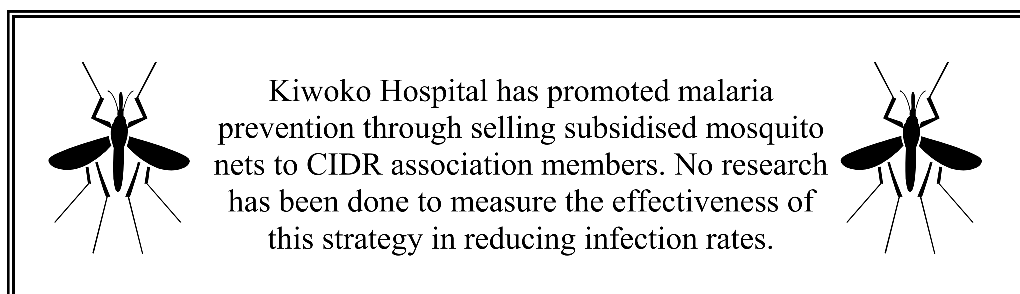
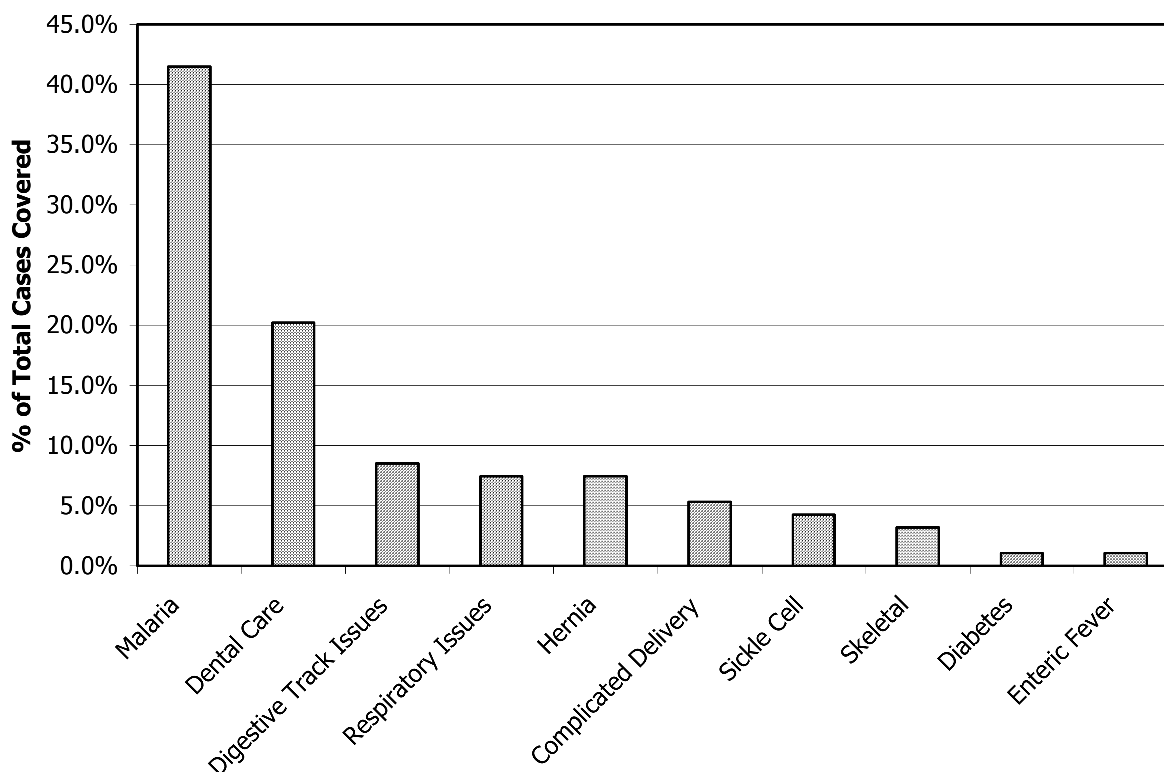
Health Promotion:
As seen in the chart below (CIDR (U) – Diagnoses on Covered Care (2001)), in-patient cases of malaria have proven to be the most pervasive cause of hospitalisation with over 40% of the admissions attributed to this endemic disease. This led the hospital to sell subsidised mosquito nets to the CIDR association members. These members pay Ushs 5,000 (US$3) for nets that would cost about Ushs 15,000 (US$8) in the markets. They have no data on the effectiveness of these sales in reducing infection rates and no work has been done to study usage of the nets or if they were simply sold again at the regular market price to others.



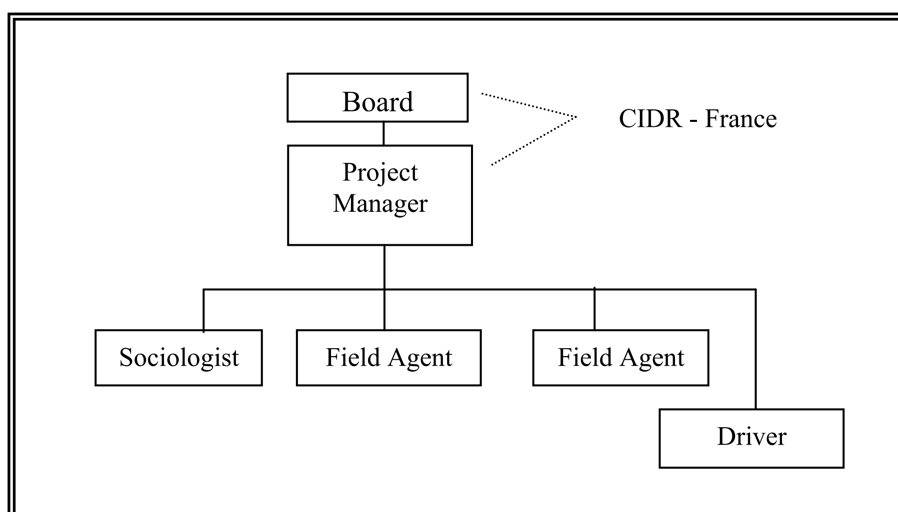
Some of the associations use their meeting times for presentations by other parties who specialise in health care maintenance and improvement, but again there is no data to quantify a benefit from these activities.



INSTITUTIONAL STRUCTURE:
CIDR is small organization with five staff members. The former Project Leader was French and was accountable to the CIDR headquarters in France. However, the institution is now transitioning into a local NGO and will be registered under the name *"Save for Health Uganda."* Under the new structure, the new Project Manager will rely on the CIDR Headquarters for technical assistance and for a portion of the Project's funding but otherwise will be autonomous. Internally, there will be minimal change to the organisational structure. The Project Manager will remain the senior manager of the Project.

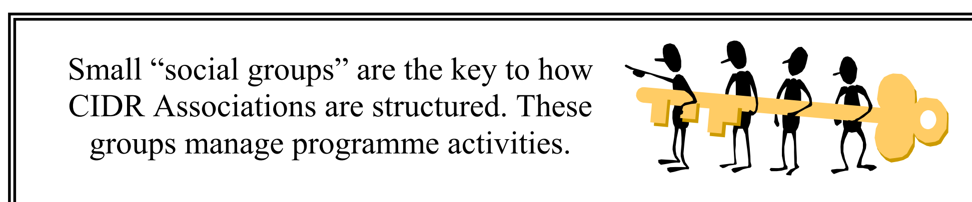
Under the Project Manager's direct supervision are two field agents, a sociologist, and a driver. The Project Manager is responsible for general oversight of the project on a day-to-day basis. The field agents are responsible for marketing the product, recruiting and training new associations, and providing technical support to the associations in the management of the scheme. The sociologist lends support to the field agents but is also responsible for carrying out research into new areas of expansion to determine the socio-economic profiles of the population and the compatibility of the product with the social structures and systems of the communities. She also conducts relevant research with current members and their program related activities. As a research organization, CIDR has placed a special emphasis on generating knowledge from its programs.

The organizational chart for this program (post reorganization) is as follows:



Health Scheme Operations:
The health scheme is set up for management at the community level and operates through village-based associations. An association consists of up to 600 members (the actual average is 120 individuals), all from the same or neighbouring villages. These associations are mobilised by CIDR with assistance from local political leaders, religious leaders, and other local notables.[6] At least 100 (for an insurance based association) or 80 people (for a credit-based association) must pay up their premiums in order for an association to be considered a part of the scheme (though this rule has been waived in order to obtain more insured rather than exclude relatively large associations). Once an association has enrolled into the scheme, the association's leadership takes responsibility for the collection and management of premiums.

For ease of management, the associations are divided into smaller "social groups." These social groups manage the program activities of their more local constituency. For example, premiums are collected by the social group treasurer and relayed to the association treasurer.



All premiums collected are, in principle, brought to and kept by the prepayment cashier on the premises of the hospital. Deductions are made against those funds as association members receive services. Initially, payouts/claims are made against the insurance fund. The service provider informs association members when the insurance fund is running low. Once the fund is exhausted, treatment for association members is discontinued and the reserves used (by vote of the association) to pay any outstanding bills with the service provider. In extreme cases, members have had to transfer money out of the management fund or contribute to cover a deficit once the reserves have run out. Others simply shut down for the balance of the year.

[6] CIDR management notes that "CIDR does not rely only on political leaders because they are, in most cases, money minded and do not work as volunteers. In fact, many of them only work with CIDR for a few months and later withdraw."

When funds are depleted, associations are entitled to an interest-free, five-year loan out of a CIDR guarantee fund in the event that other mechanisms of paying outstanding medical bills have been exhausted. The guarantee fund was set up by CIDR but it is the eventual objective that the associations will contribute annually to this fund. It is expected that this will ensure continued growth of the fund. Once this happens, management notes that they would then be expected to provide donations rather than loans to the associations in need. It is likely that with such a structure, the fund would be rapidly depleted.

CIDR tracks the number of families in each association and the number of beneficiaries in each family through an association's membership register. The organisation is also able to track levels of usage by each association. However, this is primarily for research purposes. At the association level there are standardised systems in place that have been developed by CIDR for the management of the insurance scheme.

Accounting:
The scheme has in place a simple but effective accounting function for the associations. Association leaders were trained in basic bookkeeping by the CIDR staff and carry out bookkeeping for the insurance scheme. Additionally, each association is divided into several smaller social groups, whose treasurers collect premiums from members and account for these to the association treasurer. The association treasurer in turn deposits the funds with the prepayment cashier at the hospital and accounts to the annual general meeting.

Association treasurers are responsible for accounting for all components of the premium fund. To this end they track premiums collected, claims paid out/loans taken and expenses of administering the scheme. Leadership tracks premium collection only at the beginning of the period. Premiums are based on a standard amount so it is easy for the association leadership to know exactly how many people have paid up. The member's register provides a useful check.

The accounting function is intentionally uncomplicated to make it easier for association leadership to track premiums and claims.

Accounting, therefore, is primarily a matter of tracking claims/pay outs against what is in the insurance fund and expenses against the management fund. The bookkeeping function is intentionally straightforward and easy for association members to carry out. However, effective management of the premiums and the claims against them continues to present a challenge to the associations and many have, on an annual basis, revisited premium rates versus claims paid. Three of the insurance-based associations depleted their insurance fund and reserves before the end of the period in the previous year. Two took loans to bridge the gap while the other chose to wait until the new year to restart coverage. Both credit- and insurance-based associations continue to experience deficits and still do not have an adequate understanding of the anticipated level of usage of the service. Actual usage has far exceeded the organisation's projections and while individual associations recognise the need to discourage over-usage, co-payments and ceilings on payout amounts are still inadequate to ensure that the funds last through the year.

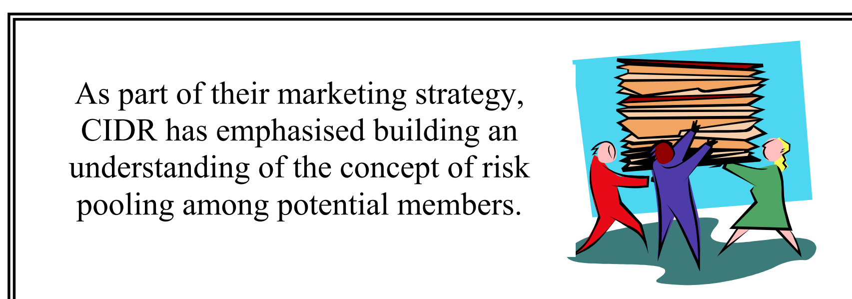
CIDR has put in place systems that minimise fraud by association members. In addition, each association's books are audited annually by CIDR staff who take the simple records and use

them to create financial statements for the association. While this entire system is manual and very simple in nature, incidences of fraud have been limited and on a monthly basis, association leaders know exactly how much is available in the insurance fund and the payouts against this amount. A key factor in the minimisation of fraud is the accountability of the prepayment cashiers.

Marketing:

CIDR does not have a marketing department. The two field staff and the sociologist do marketing for the scheme. One of CIDR's strengths is a reasonably thorough marketing approach. They have organised trainings, and use posters, drama and promotional items, like subsidised calendars and T-shirts. Posters clearly outlining enrolment procedures are distributed to all associations and association members have received repeated training regarding how the product works.

Marketing efforts consist not only of trying to sell the product, but field officers also emphasise building an understanding of the concept of risk pooling among potential members. CIDR staff uses examples from neighbouring villages where the scheme is working to persuade new members to enrol. Association members acknowledge that this strategy was particularly effective especially since those in neighbouring villages will have heard about the benefits of the scheme from the current members.



Clear annual outreach targets guide the activities of field agents. Targets for the coming fiscal year have already been set and new enrolment targets for this fiscal year have been largely achieved. However, in spite of diligent follow up and a close relationship between project staff and the members, re-subscription rates have been very limited in prior years and for the current year none of the three insurance-based associations renewed. The effects of moral hazard and adverse selection have hit these associations particularly hard. The credit-based associations have fared much better and the re-subscription rate for these has been well above 90%. CIDR and the members attribute this high rate to the fact that to receive continued access to the loan pool, members were only required to pay a small amount to cover management costs of the associations.[7]

Overall:

While "ownership" of the scheme is with the associations, the associations are still heavily subsidised (in terms of oversight costs, stationary, and others) by CIDR. Drop-out rates and the ratios of claims to premiums are high for the insurance-based associations. These and other ratios can be tracked at an institutional level, but they somewhat distort the actual activity of the individual associations.

Some ratios calculated during the visit include:

[7] Currently, no association pays fees to its management.

- Insured to CIDR staff as at June 2002: 209 (837/4)
- Administrative costs to Premiums: Administrative costs are borne by the association leadership. These are unpaid positions and thus administrative costs are not easily calculated. Costs of CIDR do not relate to premiums since these are held entirely by the associations.
- Drop-out rate: For the insurance programme the drop-out rate was 48% in 2001 renewal season, and 100% in 2002 (because none of the insurance associations were able to get enough members to pay up their premiums). The credit scheme saw about a 2% dropout in 2001, and this is likely to be similar in 2002. Drop-out in the credit programme is very limited because once a member has paid an initial capital contribution, annual fees simply cover the minimal association operating expenses, so remaining in the association is cheap and easy.
- Claims to Premiums: This ratio is only relevant for the insurance-based associations. Data was only available for one such association (Kiruuli Association) and their Claims-to-Treatment Fund Premiums ratio was 133%. When the Security Fund was used to cover claims in this case, the ratio fell to 113%, still not sufficient to cover the costs of care.
- Change in premiums written: 82% for the period February to May 2001 for the insurance based associations. However, only one of these associations renewed its membership for the prior year. This ratio is not relevant for credit-based associations that make a one-time contribution to the fund.
- Days of unpaid claims at any point: Zero. The prepayment cashier goes to the village once per month with the invoice and settles any issues there. At the conclusion of that meeting the association signs the withdrawal authorisation and the cashier takes the money on return to the hospital. This constitutes immediate payment.
- Reserves to claims: Only available for one insurance-based association for the last fiscal year. The reserves to claims for this association at that time were 12%. The policy is to initially allocate 12% of gross premiums collected to the Security Fund.

Likelihood of Sustainability:
Left on their own, there is little likelihood that the associations will become institutionally or financially sustainable. Associations are still heavily subsidised through CIDR oversight, loans, training, and technical assistance. They only bear a small percentage of the entire cost of administering the scheme. Also, the associations still heavily rely on CIDR for oversight and ongoing training. Management capacity of association leaders is limited and they are only capable of carrying out basic bookkeeping functions but not of effectively managing the insurance scheme.

Insurance based associations:
These have suffered from adverse selection and moral hazard and as earlier stated, a few of them had depleted their insurance reserves midway through 2001. Most have tried to put in place controls including co-payments and ceilings on treatment costs covered. However with lack of professional input in pricing and risk underwriting they are likely to continue to face problems with running the fund. The associations recognise a need to re-price the product. However, they also realise that this will only drive away larger and poorer families and further decrease the insurance pool. The result has been a total loss of insurance option associations during the year 2002.

Credit based associations:

Credit-based associations are certainly faring better than their insurance-based neighbours at least in terms of member retention. However, many are facing cash flow problems because of increasingly later repayment in spite of the stipulated three-month repayment period. Some have had to take credit from CIDR to bridge the gap when repayments are slow in coming in. These credit-based associations lack effective collection mechanisms. The need to preserve social goodwill and the fear of creating antagonism with neighbours if timely collection is enforced further compounds the collection problem. CIDR notes that credit-based associations are much better suited for the Luweero market, however, they recognise that without the capacity to collect on late repayments internally, this is unlikely to work for long. Management noted that they intend to discuss options for management of these schemes with microfinance institutions in the near future.

Since it is unlikely that these associations will become sustainable in the long-term, it may make sense to link the credit based associations to a microfinance institution for health loans with CIDR or Save for Life continuing to provide technical assistance to the associations. This might require a significant restructuring of the existing associations and the weeding out of individuals who are incapable of effectively servicing credit. The associations might then use their collected premiums to leverage credit. In this case, loans would be paid out directly to the service provider and each association member would then be responsible for servicing his/her loan. Alternatively, MFIs could simply offer an emergency health care loan paid directly to the provider for individual members.

MANAGEMENT AND GOVERNANCE:

A three-member team manages the associations, while two members lead the smaller social groups. Previously there had been a long list of association leader positions. This has been minimised because the other positions were deemed unnecessary and difficult to cover.

PARTNERSHIPS

The essential relationships here are between the providers and the association, and the association and the social groups. CIDR oversees these relationships with their focus on building strong institutional relationships that can become sustainable without additional CIDR input.

	PROVIDERS	ASSOCIATIONS	SOCIAL GROUPS
Objectives and Expectations	▪ Gain more patients ▪ Have a growing percentage of their patients prepaying for care so they can minimise collection efforts.	▪ Get better health care ▪ Gain access to funding for health care to minimise the financial shocks when events occur ▪ Save money on health care	▪ Get better health care ▪ Gain access to funding for health care to minimise the financial shocks when events occur ▪ Save money on health care
Relationship	▪ Strong relationship with frequent meetings and communications	▪ Strong relationship with CIDR ▪ Strong paternal link to social groups	▪ Strong relationship with CIDR ▪ Strong link to association

Roles Within the Relationship			
	PROVIDERS	**ASSOCIATIONS**	**SOCIAL GROUPS**
Partner role	▪ Provide in-patient health care ▪ Safekeeping of association premiums / revolving fund ▪ Invoice preparation, delivery, and presentation	▪ Oversee social groups ▪ Negotiate partnership with provider ▪ Increase membership ▪ Manage association finances ▪ Pay provider invoices	▪ Mobilise local membership ▪ Collect premiums and revolving fund payments
CIDR role	▪ Mobilise and train new associations ▪ Moderate provider association relationships	▪ Mobilise and train new associations ▪ Moderate provider association relationships	▪ Mobilise and train new groups ▪ Moderate provider association relationships
Capacity demands	▪ Minimal. Provider manages their role successfully	▪ Significant. Full development to autonomy may not be possible	▪ Significant. Full development to autonomy may not be possible

LEVELS OF MEMBER SATISFACTION WITH THE PRODUCT

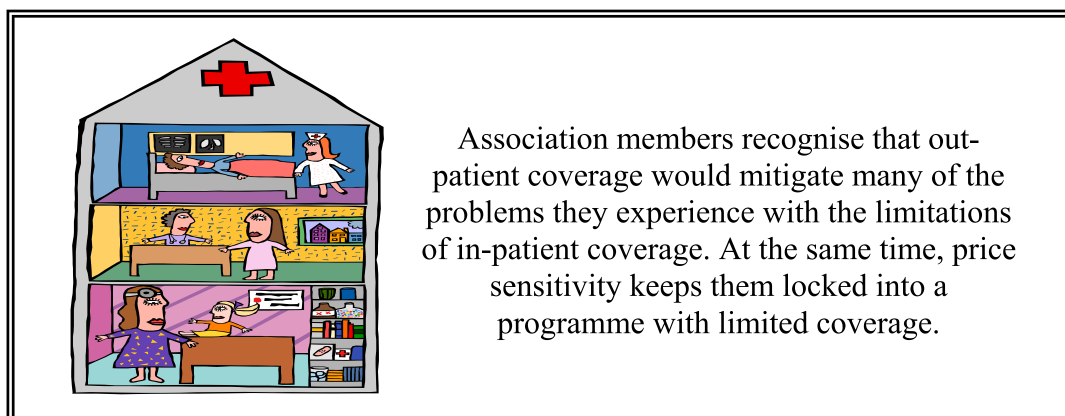
While CIDR has standard credit and insurance options for administering its product, association members are involved in the design of the specifics of coverage, exclusions and pricing for the product. This was done to create a sense of ownership and where the product was not working well, association members recognised that it was their role to put in place controls and innovations to make the product work better. As an example, some associations have introduced limitations to treatment amounts per visit while others have introduced co-payments in a bid to mitigate moral hazard and over-consumption.

Generally, the members are happy with the product. They liked the fact that as members of an association they could afford hospitalisation even when they had no money on them. They appreciated not having to worry about inability to pay the bill when they were hospitalised. *"We used to be locked up in a cell in the hospital for non-payment,"* they said. Members realise the merits of having access to a well-equipped hospital and acknowledge the superior quality of healthcare available through Kiwoko hospital. Before they joined the association, the members who participated in this study admitted that they had to borrow or sell assets in order to pay up medical expenses. Many of them had relied on self-prescription and others held off taking the patient to hospital as long as possible to the point where some of them lost family members who would have otherwise lived.

However, for many of the associations, the distance to Kiwoko remains an issue. The cost of a return journey to the hospital was such that they never went to the hospital unless they were sure that they were sick enough – and many of them were never sure they were sick enough. As a result, adversely selected members ended up benefiting at the expense of the rest.

Each association has the opportunity to decide on its own coverage limits and most associations have chosen to cover only in-patient care. CIDR management notes that they develop premiums for in-patient and out-patient coverage. These are provided to association members and after reviewing them, the members almost always settle on in-patient coverage, "which is low and affordable."

In many cases, a patient is not sure they are sick enough to be admitted. As a result, association members have sometimes gone to a nearby clinic for patient care only to be admitted there. Those who have had this experience find it awkward to refuse admission by their out-patient clinic and therefore end up not benefiting from CIDR coverage. Association members see out-patient coverage as the solution to this. However, while they recognise the inadequacy of having coverage only for in-patient care and the fact that it encourages many people to go to hospital very late in the illness cycle, they also recognise that including out-patient coverage would require premiums that are not affordable for most of the association members. They also acknowledge that it is for in-patient care that most of them need to pool the risk because is relatively expensive and it is the money for in-patient care that most of them have trouble accessing.



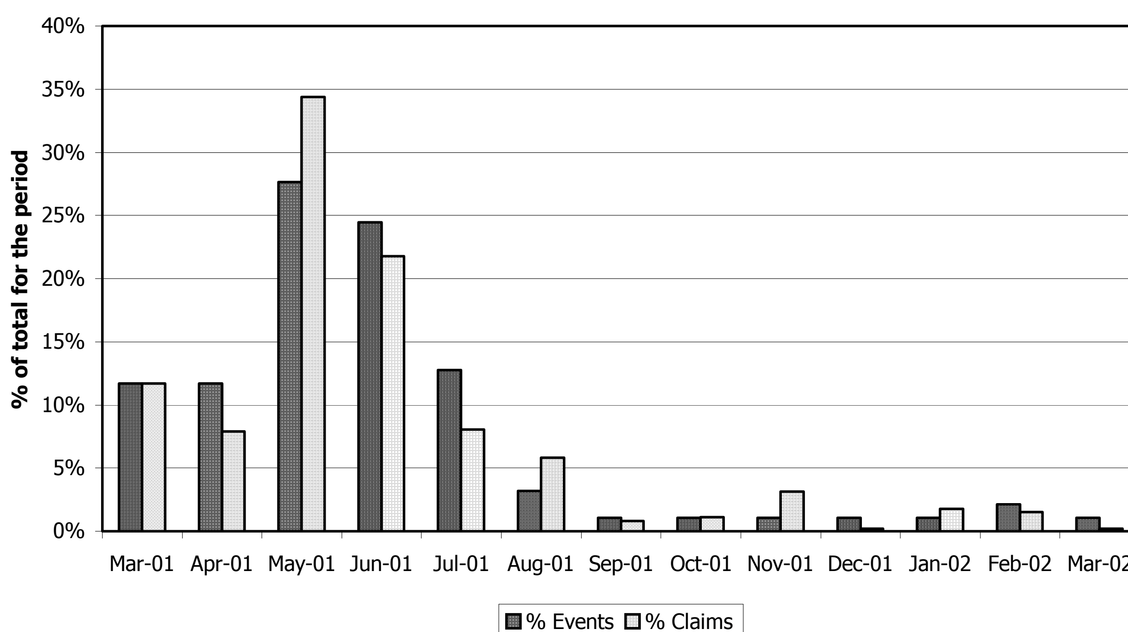
Two key indicators of member satisfaction include (1) their continued participation and (2) growth of the program. CIDR has experienced rather slow growth and they are beginning to suffer significant drop-out. The table below (CIDR(U) – Growth in Members and Associations) shows that growth was significant from Year One to Year Two, Year Three showed little net growth even though there were four new groups. In fact, these new groups simply replaced the four groups that left the program. Drop-out occurred mostly because the associations in question were unable to generate the full premium from their members. Additionally, new growth has clearly suffered given that the membership for 2002 was projected at 1,400 members versus the actual 837 that were generated.

CIDR (U) - Growth in Members and Associations

				Number of Associations		
Year	Families	**Members**	Avg. M/F	Old	New	**Total**
2000	96	**373**	3.9	0	4	**4**
2001	241	**812**	3.4	4	3	**7**
2002	163	**837**	5.1	3	4	**7**

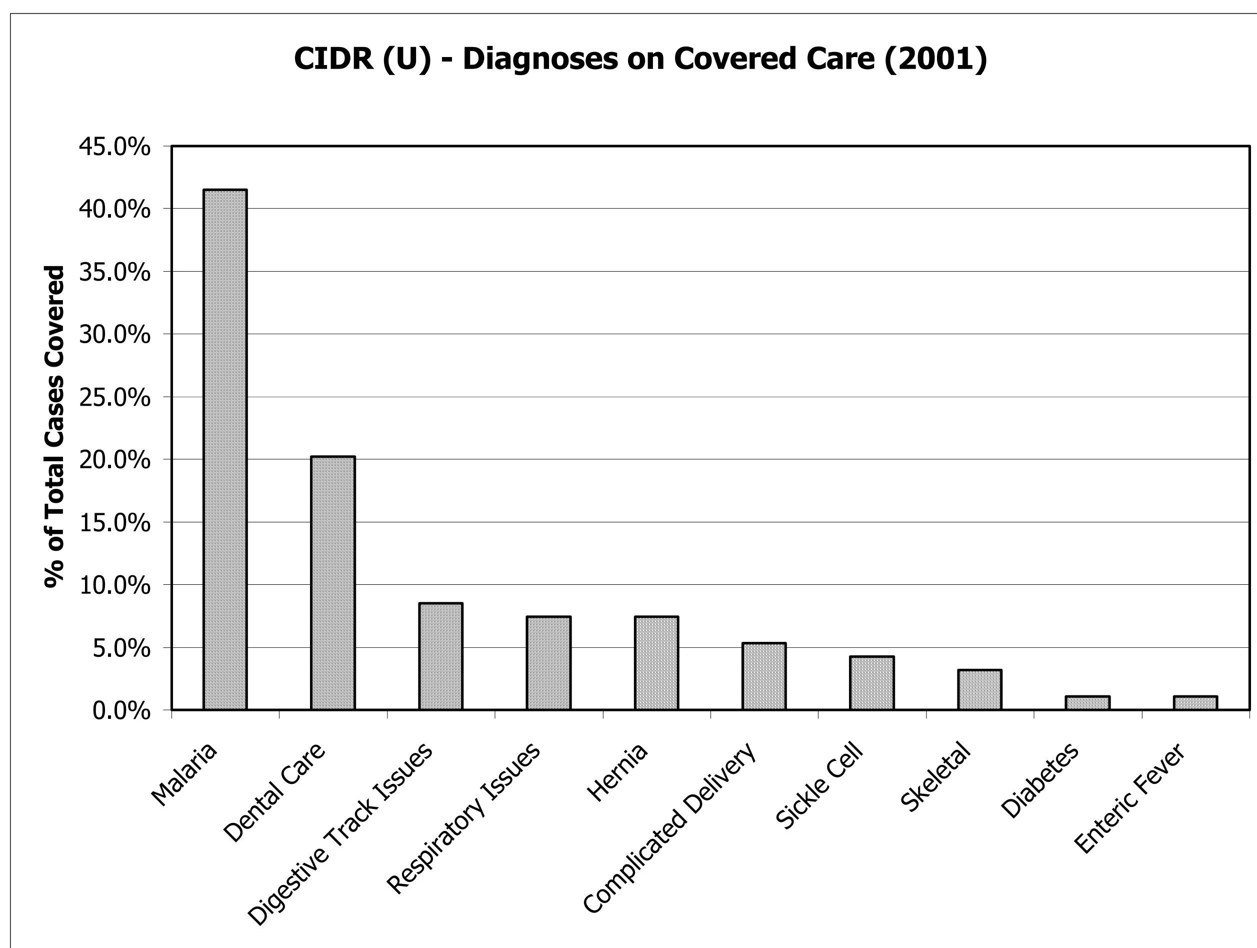
We can also see from this table that the size of member families, on average, is increasing. This is at least partially related to the policy change that created a tiering approach to premiums whereby larger families receive a discount on the per person rate.

Utilisation has been significant especially in the first part of the premium year. For five of the seven groups, premiums are paid in February or March, while the remaining two are paid in May and June. The chart below (CIDR (U) Utilization Volume and Value of Care by Month (03/01-03/02)) shows utilisation volume and values throughout the year. Interestingly more than ninety percent of all activity occurs in the first six months of the premium year. This could point to several things including illness seasonalities, but also supports the point made by CIDR management that the insurance groups run out of funds early in the premium year. This would have a dramatic negative impact on potential growth and member retention. It was explained that insurance groups, when they do stay in the program, would likely shift to credit based associations in subsequent years.



An important issue arises when reviewing utilisation by the two types of product – insurance and credit. CIDR records from the premium year ending 2002 showed that 13.5% of insurance type association members utilised the facility versus only 4.4% of credit type association members during the same period. The difference is wide enough to generate questions, especially when we consider that insurance type associations depleted their funds before the end of the premium period, and thus their access was more limited than that for the other associations.

Adverse selection is an easy potential reason for such a difference between association type utilisation. However, reviewing the diagnoses as in the chart below (CIDR (U) - Diagnoses on Covered Care (2001)) shows that the vast majority of diagnoses were for emergency type treatments. It is clear that when people consider the purchase of insurance products, they look for a net benefit. It may be that those who choose insurance are those that believe their families are more susceptible to illness, while those that choose the credit option are confident in the health of their families, but may want to protect themselves from the unlikely possibility of hospitalisation with very little risk. The one capital payment and continuing small management fees allow for such a strategy. This issue clearly requires more research.



RISK MANAGEMENT

The risk in this program lies substantially with the members themselves, with the balance falling to the hospital. CIDR does back up some financial deficiencies, though its liability is limited to credit risk in terms of its small loans to the associations and usually provided in increments of Ushs 50,000 (about US$28). These loans have been minimal.

A key issue for associations is: are they able to assess and manage the risk of their membership? From the response of both CIDR pulling back support after three years of working with these associations, and the members themselves who have abandoned the insurance option, it seems clear that at this point they are not able to assess and manage risk, and are not likely to be able to do so even in the long term.

With the credit associations, risk (resulting from non-payment of the loans) is spread out to the rest of the association members. In these associations, social group members have sometimes had to repay another member's loan in order not to lose access to service.

Risks to Partners:

Association membership absorbs the risk through a reserve fund that is created from premiums. Beyond that they must borrow limited amounts from CIDR or reach into their own empty pockets to complete payment.

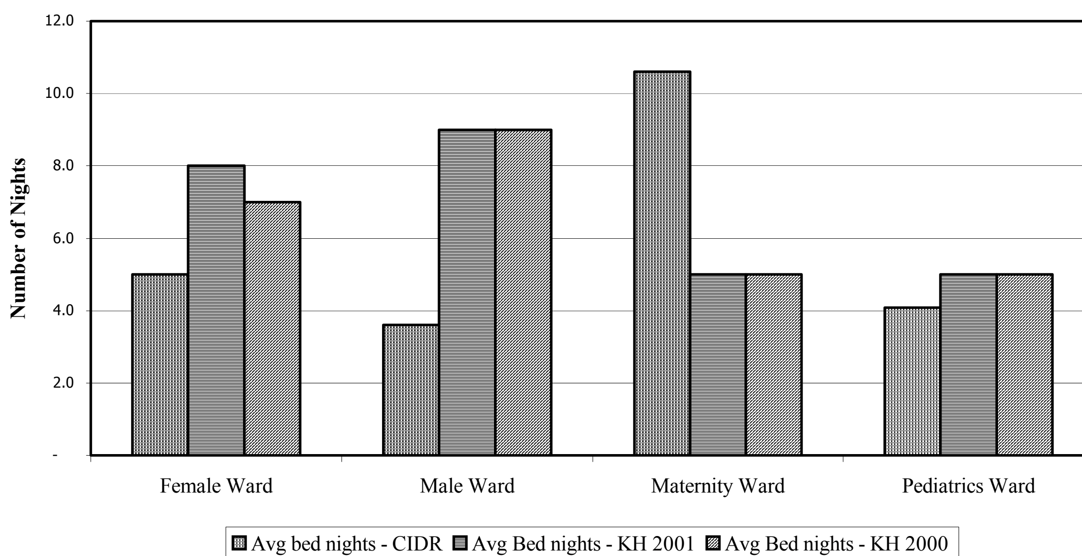
Associations are able to take out small loans from a CIDR fund to meet shortfalls in their own insurance funds. Loans from the fund are interest-free and for terms of up to 10 years. The policies governing this guarantee fund are rather lax and it is likely that the fund will be depleted over the next few years. The credit risk to CIDR on this product is substantial although the values are limited.

There is also some risk to Kiwoko hospital as the health care service provider, but this is also limited because they control the care and thus expenses with knowledge of the funds available to pay themselves from the association's pool of funds. Services to association members are discontinued before the fund runs out. When this happens, the association uses the balance in the insurance fund plus transfers from the reserves to cover outstanding medical bills upon a vote.

INCENTIVES:

The incentives to improve health in this case lie with the association itself. Unfortunately, they are least capable of generating such improvement. In fact, the incentive that they have is to reduce access to the health facility. This is done through increasing co-payments in mid-term and creating maximums in order to minimise the reduction in their fund.

The hospital has an incentive to earn more money from these patients and thus hold them longer. However, no indication of this was found. In fact in all cases but maternity admissions, the CIDR patient stays were shorter than the average for the hospital. In the case of maternity, only difficult maternity cases are covered by the insurance since most natural births are done at other, cheaper, facilities. The table below shows the relationship of CIDR bed nights to those of the hospital average.



SWOT ANALYSIS

A summary of the strengths, weaknesses, opportunities and threats related to the CIDR Community-Based Health Prepayment Programme is outlined in the table in Appendix 2.

LESSONS LEARNED

Product:

- **Follow your own policies.** CIDR initially found deficiencies in the social cohesiveness and expectations in the Luweero market but went against their normal procedures to start this project. Now they note that the insurance product is ill suited to this market. In the meantime, they have missed all significant growth targets and are now scaling back the programme with the realisation that primary objectives of association autonomy are likely to take more than ten years to achieve, if ever.
- **Emergency credit** for health care can be more appropriate than insurance. The credit option has been selected 75% of the time by CIDR associations. Members clearly understand credit better than insurance and these programs show a very high retention rate. Credit risk issues are arising, but likely because of the community's inability to effectively collect loans among themselves. This product is likely adaptable to MFIs (who are often better skilled to collect loans than local members). Management noted that they are entering discussions with MFIs to potentially manage the credit part of their programme.
- Access difficulties for in-patient-only products need to be addressed to limit "**access risk**" of insured. With this plan, insured had a need to confirm likely admission before going to the provider hospital. To go to the provider hospital thinking they were ill enough for admission meant spending money on transport to the hospital as well as the consultation and tests at the hospital to determine admitability. If admitted, usually only once in every three visits, all this is covered. If not admitted members must pay the costs. The cost for out-patient care at a local out-patient care provider would usually be less than the cost of transport alone to the hospital. One of the credit-based associations has added out-patient care to their coverage to address this problem.
- An insurance programme must consider convenience of access to the health care provider. The distance to the hospital is a serious factor in determining utilisation and purchase of the insurance policies.

Operations:

- It is difficult for an organisation to enforce a rule requiring all members of a household to join the insurance scheme. Confirmation, especially in a community-based context where members will not enforce such rules upon other members, can be easily eluded. It may be better to require a minimum number of entrants from each family.

Marketing:

- Insurance marketing must begin with training. Insurance concept are difficult for potential customers to understand and significant time must be spent getting them to understand risk pooling in addition to understanding the product and its management through a mutual scheme.

Accounts:

- Safekeeping of funds by the hospital gives the hospital an important control mechanism that helps minimise what is, effectively, their credit risk.
- Having the hospital submit an invoice in person to clear up any questions immediately can result in faster claims payments.

Partners:

- A hospital partner may be willing to accept additional responsibilities in order to ensure their "captive" market. In this case Kiwoko Hospital now pays for a focused (though not

fully dedicated) cashier, provides an office in the hospital for that cashier to work with insured, and safekeeps the association's premiums.

Appendix 1: Managing Insurance Risks: Strategies used by CIDR in its Health Prepayment Programme
Audit of funds at the hospital, holding the funds at the hospital

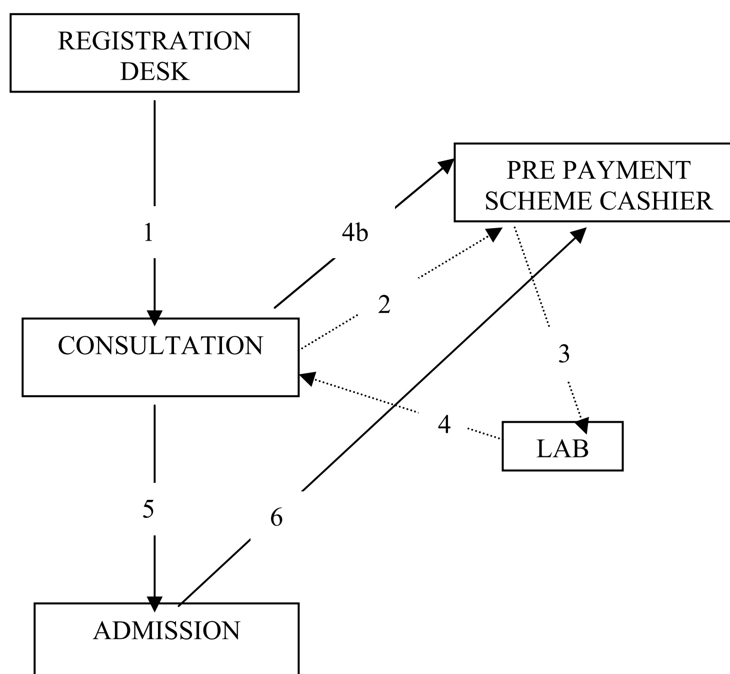
Risk:	General Strategy:	Specific Strategy:
Moral Hazard	Pre-selected providers	CIDR works with one hospital only
	Claims limits	Some associations have implemented claims limits to control outflow
	Co-Payments	Some associations have initiated co-payments as a means of controlling outflows
	Loss review	There is no review of claims versus illness though the in-patient only focus helps to control this through limited utilisation
	Exclusions	Outpatient care, alcoholism related incidents, elective surgery, self-inflicted injuries, and dental plates.
		Any care provided outside Kiwoko Hospital
	Waiting periods	Three months during the premium payment period
		Only one annual joining period
	Proof of event	During the monthly invoice payment sessions with the prepayment cashier the event is reconciled between the patient and the hospital records.
	Client identification	Membership cards are provided for every family
		Membership cards are replaced every year
	Pre-approval of treatment	Not required
	Expense verification	Associations do not maintain pricing sheets from the hospital
	Deductibles	No deductibles
	Initial exams	None required
	Use of pre-existing groups	CIDR creates associations within villages. The village structure is intended to provide the benefits of a pre-existing group, however in Luweero this was not the case.
	Prerequisites to care	Must be admitted
	Membership from existing groups only	The programme targets a single village for a scheme, but members can come from nearby villages. This facilitates expansion in subsequent years.
Adverse Selection	Whole family membership required	All people living under one roof are required to join if one from the house does. In CIDR's initial feasibility study, the average family size in Luweero district was estimated at 6. However, the actual family size in the associations is 3.8. Associations lack controls that ensure that each household enrols all its members and households are enrolling sickly members with the result that the insurance fund is depleted before the lapse of the period of coverage. Introduction of co-payments and limitations to claims sizes by associations have not mitigated this problem.
	Required membership within groups	Must reside in the village
	Defined risk pools	No defined risk pools. Each association sets a premium for all its members based on the package of coverage the association selects. Discounts are provided for larger families, but this is not related to any risk assessment.
	Waiting periods	Three months during the premium payment period
		Only one annual joining period
	Tying insurance to other products	Insurance is not tied to any other product
	Periodic cost evaluation	This is not conducted
Cost escalation	Preset pricing agreements with providers	No fixed pricing agreements with hospital

Risk:	General Strategy:	Specific Strategy:
	Preset drugs list	No drug restrictions
	Discounts	A discount of 10% is provided by the hospital.
	Co-payments	Some associations require co-payments
Fraud and Abuse	Computerised ID systems	Photo ID but not computerised
	Coverage limits	Some associations maintain limits but only for chronic care patients (Ushs 50,000 or US$28)
	Physical identification	Photo ID card
	Regular financial review	Monthly comparison of the providers' records with those of the association serves to ensure consistency to safeguard against fraud.

Appendix 2: SWOT Analysis

CIDR Health Prepayment Programme: SWOT Analysis			
STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
PRODUCT			
Credit product enjoys high renewal rates	In-patient cover only, encourages patients to come very late in illness cycle	Wide untapped market	The loss of direct CIDR oversight
	Weak pricing leads to capitalisation problems	Potential to link credit product with an MFI	Fraud is a constant threat in community based organisations
	Distance to provider		
OPERATIONS			
System is basic and should be easy to manage by associations	Associations do not appear to be independantly sustainable due to a lack of capacity	If capacity were present there would be low administrative costs	The loss of direct CIDR oversight
Reputable provider offering good quality healthcare	Inadequate controls against adverse selection		Fraud is a constant threat in community based organisations
	Too much reliance on CIDR		
MARKETING			
Good emphasis on educating communties about risk pooling	High non-renewal rates	Large potential market	Low levels of renewals
Use of examples has been effective	Internally limited growth		
ACCOUNTING			
Simple, straightfoward bookkeeping procedures	Lack of adequate capacity to manage insurance funds by association leaders		Poor pricing and tension in the need for adequate capital and reserves threaten sustainability of associations
Cash held by hospital	Poorly priced product		
Invoice collection mechanism strong and makes payment immediate.			
RISK MANAGEMENT			
A credit option that minimises moral hazard	Inadequate controls against adverse selection and moral hazard in insurance option	Groups are refining controls based on their loss experience in order to try to balance cost and controls with ability to pay.	A key requirement is financial oversight by external agents (the hospital and CIDR)
Cash held with hospital	Groups not experienced enough to design or manage effective controls		
Fund balances allocated by CIDR			

Appendix 3: Patient Flow at Hospital:



NOTES:

- Sometimes the doctor recommends admission without requesting lab tests and patient skips steps 2 through 4. However, if doctor requests lab test and results reveal that the condition does not warrant admission, then patient skips step 5 and instead must pay for the out patient services received (step 4b).
- All patients upon discharge go to the prepayment cashier (step 6) and are issued with a certificate of coverage indicating total costs of admission. If cost exceeds agreed limits (set by the associations) then patient pays balance at that time.