"Developing partnerships to insure the world's poor"

POVERTY AFRICA HEALTH PROGRAMME – HEALTH MICROINSURANCE

Dar es Salaam, Tanzania

Notes from a visit 10-12 July 2002

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

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INTRODUCTION AND BACKGROUND

Poverty Africa (POA) is an international Non-Governmental Organisation (NGO) headquartered in Dar es Salaam. The corporate philosophy is that any organization that aims to significantly assist the poor must use a multifaceted intervention involving economic empowerment, education and health interventions.[1] Poverty Africa's belief in a holistic approach to development leads them to a range of interventions including:

- Microfinance
- Education
- Nutrition
- HIV/AIDS prevention
- Healthcare microinsurance

POA had already been operating a health programme – with a clinic providing free care to the very poorest and a disease prevention education program – when the idea of an insurance scheme emerged. The organisation has always worked with low-income communities and had observed the level of financial stress that health problems caused. The lack of access to quality health care by the poor concerned the institution.

The government of Tanzania has a wide network of dispensaries, health centres, and hospitals. However, most of these are understaffed and ill equipped. A shortage of skilled care providers has resulted in many dispensaries being managed by primary school leavers with only very basic medical training. The health insurance scheme was started to address these issues. The initial focus region was Dar es Salaam, which has a population of about 2.4 million (of a total 34 million people in Tanzania). The program's target was to reach at least 100,000 individuals in its first year.

To date, after thirteen months of operation, about 600 individuals are covered by POA's health insurance scheme, of which 350 are in Dar es Salaam. Most of these are low-income corporate employees. POA mainly serves smaller companies and individuals. The corporate market has been more responsive to the product than individual families and community groups and this market is therefore perceived by the scheme to have the greatest potential. Additionally, the corporate market provides a relatively non-adversely selected pool of insured. However, even here, growth was much slower than anticipated. This was partly because of the over-eager estimates and limited market research. But it was also because of stiff competition from HMOs such as AAR and MediGuard who are also aiming at the corporate market but with more effective marketing strategies and better linkages with parastatals and government.

POVERTY AFRICA'S PRODUCT

POA's health insurance is delivered through three "modules" that offer access to:

1. Basic out-patient healthcare ("Module 1"),
2. In- and out-patient care including simple surgeries and ambulance ("Module 2"), and
3. All the services available under the first two modules, plus complicated surgeries ("Module 3").

The intention of this approach was to develop different packages to suit different needs and budgets.

[1] The authors would like to thank the management and staff of Poverty Africa as well as their partners and clients for their kind assistance during our visit. They were extremely open and helpful, answered all our questions and clarified many issues for us.

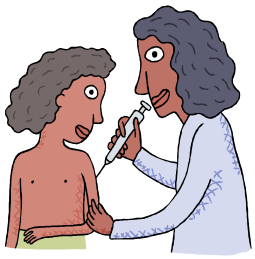
PRODUCT			
Eligibility Criteria	▪ Open to both corporate bodies with low-income employees and individual families that can afford to pay the premiums		
Coverage	Module 1: basic primary healthcare (out-patient only)	Module 2: in- and out-patient care, simple surgeries, and ambulance coverage	Module 3: in- and out-patient care and entire range of surgical procedures
Duration of Coverage	▪ One year		
Exclusions	Module 1 excludes in-patient care or surgery of any kind	Module 2 excludes complicated surgery	
	▪ AIDS and chronic diseases <u>are</u> covered as per the module purchased		
Limitations	▪ Treatment and medication restricted to WHO care guidelines (but these are not followed in practice) ▪ Service is limited to a single designated care provider that clients choose. After choice has been made, the provider becomes their assigned provider. ▪ No care is provided during the first month of "cover"		
Mode of Delivery	▪ A network of twenty-five provider facilities (eighteen in Dar es Salaam, and seven "up-country"). Patients choose a provider from a list and this become their designated provider. Key considerations in assigning the provider are accessibility and the type of coverage purchased		
PRICING			
Premium	Module 1: Tshs20,000 per person per year (US$21), or Tshs30,000 (US$32) if it is purchased by an employer[2]	Module 2: Tshs 50,000 per person per year (US$64), or Tshs60,000 (US$64) if it is purchased by an employer	Module 3: Tshs 200,000 per person per year (US$213)
Method of payment	▪ A lump sum premium payment is required at the start of the period. ▪ Instalment payments are allowed, though coverage is not valid until the entire premium has been paid. This rule is not universally followed.		
Other	▪ No other fees (no co-payments, no deductibles)		
PLACE			
	▪ Care at designated clinic/hospital ▪ Premium payment at employer site and POA office		
PROCESS			
Enrolment/Renewal	▪ Sales agent makes contact with client, disseminates information on product ▪ Client (individual or corporate) makes decision, fills in application form and comes to POA Office to pay ▪ An ID card is prepared for each beneficiary		

[2] The exchange rate at the time of the visit was Tshs940 to US$1.

Receipt of Treatment (a detailed process diagram of the process for receiving treatment is included in Appendix 3)	▪ Patient presents POA ID card at hospital/clinic reception (registration desk) for verification by facility registration officer. No payment is required. ▪ Patient receives consultation ▪ If patient needs to go to lab, doctor makes a referral for tests ▪ Patient returns to doctor for prescription ▪ Patient submits prescription to pharmacy and receives medication
PHYSICAL EVIDENCE	
	▪ ID card ▪ Application form ▪ Contract with hospital ▪ Medical form ▪ No written policy
PEOPLE	
	▪ Marketers ▪ Hospital/clinic registration desk personnel ▪ Physicians and nurses
PROMOTION	
	▪ Word of mouth ▪ Commissioned sales staff ▪ Initially through TV and radio ▪ Simple printout with module descriptions

HEALTH PROMOTION

POA as an organisation has a health programme and offers information on nutrition and HIV prevention that complements but is not formally a part of the health microinsurance packages. In principle, members are entitled to a thorough check-up at the beginning of their period of cover. However, no "check up" visits have been registered so far. Scheme members only visit healthcare facilities when they are ill.



Immunisations and antenatal care are offered to clients, but not linked to future care.

In addition to the check-up visit, the institution offers immunisations for children and antenatal care for expectant mothers. However, unlike many other organisations that offer such care, future access to treatment is not linked to the requirement that a patient must have undergone the immunisation or antenatal care. Ideally, the institution could link certain types of paediatric treatment to immunisation requirements as a control against moral hazard. Similar conditions could be put in place for expectant mothers.

INSTITUTIONAL STRUCTURE

The microinsurance scheme is one of a range of interventions by POA and operates under the institution's health program. The scheme's director is also the national coordinator of POA's

health programme. While the institution has in place many related activities, there is no intentional overlap between these and the microinsurance programme, though some of the activities are conducted within the same geographical area. So far, there is no institutional initiative to create formal linkages between the different and potentially complementary programs.

Until very recently, health scheme management was accountable to the main POA Board. However, in May of 2002 the scheme convened a separate board. In addition to the director, the scheme has only two permanent staff; a finance manager and a resource mobilisation manager (a grant writer). Three commission-based staff carry out the marketing and report to either the finance manager or the resource mobilisation manager. Because of the financial constraints under which the scheme operates, even the full time staff are currently working as unpaid volunteers.

HEALTH SCHEME OPERATIONS

The scheme works through a network of selected health service providers. All selected providers were invited (not required) to a seminar at the start of the scheme. Topics covered included:

- ✓ What is microinsurance?
- ✓ How microinsurance works
- ✓ Principles of successful microinsurance, and
- ✓ Treatment of insured clients.

There was no formal training relating to the relationship between the partners, or the procedures for processing claims and other transactions. These are said to have been discussed informally. It is evident that the providers are not applying the principles discussed in this seminar and that the procedures are not being adequately followed. The scheme's management recognises that skipping a formal training on procedures was a mistake and thus plans a refresher seminar.

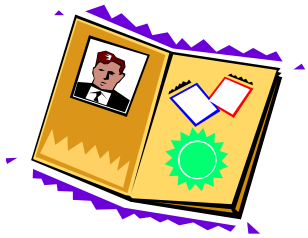
At the scheme's inception, the scheme director visited many reputable healthcare providers to try to negotiate partnerships with them. However, most of them perceived insurance negatively and were not open to taking the risk of working with a health insurance scheme that targeted the low-income market, was in its very initial stages, and had an unknown reputation (except as a give-away program). The current health service providers were thus primarily selected because of their willingness to take the risk in order to gain clientele. This suggests questionable health care quality, a need for a "risk return", and little control over the relationship by POA. These are all dangerous factors for an insurance program.

The scheme's management is aware that many of its provider-partners fall short of acceptable health care standards in many ways. In an attempt to ensure a certain minimum standard, the scheme's director – who is also a physician – personally visits and inspects the facilities of each potential partner to certify that they conform to WHO guidelines as is required by the Government of Tanzania. At a minimum, providers are required to be registered with the government and to have in place consultation, diagnostic, and pharmaceutical facilities. Unfortunately, the WHO guidelines are also rather lax and even though provider facilities have an examination room, a lab and a pharmacy, all three are in many cases ill equipped. The result is a set of provider partners who are incapable of delivering what would reasonably be considered "good" quality healthcare. Moreover, the scheme lacks systems for monitoring the quality of healthcare given by the providers. In addition, the scheme does not have in place a system through which patients can give feedback on the quality of healthcare received from the providers.

Ideally, providers who are incapable of delivering a high standard of healthcare should be dropped. However, the scheme still has serious problems and is not in a strong enough position to negotiate better arrangements, and has therefore been forced to make do with the available providers.

Each scheme member has a photo identification card. Members are expected to present their ID to the receptionist at the provider's facility prior to receipt of treatment. However, validation of membership is left up to the providers who have no incentive to prevent fraud. It is possible, even likely, that in some instances non-insured family members use policyholders' cards to receive treatment.

Photo identification cards are important, but there must be incentive for providers to help a health plan prevent fraud, and a mechanism to help them to do so.



Initially the agreement was that providers would submit their bills monthly and receive payment within thirty days of submitting their invoices. However, as cash flows became tighter, the period between receipt of bills and settlement of claims has lengthened. Providers now receive only partial payment and even that now comes after the agreed thirty-day period. So far, the scheme has not lost any of its provider partners and while the partners are losing patience they still continue to provide healthcare to scheme members.

Providers offer a discount of twenty percent for consultation with specialists. However, many of them also clearly inflate treatment charges. With no treatment limits in place, providers have incentive to over-prescribe and to order unnecessary lab tests. Unfortunately, patients do not have an incentive to prevent these practices since there are neither coverage limitations nor co-payment requirements. This combination has encouraged frivolous patient care. There is no standard price list in place with providers and pricing of medical services is left entirely to providers who have a very strong incentive to inflate costs, against a scheme with very limited ability to enforce controls.

Plans need to be careful about how they calculate premiums. Many factors must be considered in product pricing. Without the right price, institutional pockets will be empty!

Scheme management calculated the premiums for the insurance product based on averages of the number of out-patient visits over one year to one dispensary in Dar es Salaam. Total out-patient visits at this dispensary were five thousand over the year. This information was analysed to derive an average frequency of individual visits. These figures were compared to frequency of utilisation data from the Ministry of Health (an average of four outpatient visits per year) and apparently found to be reasonable. The average frequency data was than multiplied against an

average cost per visit to arrive at the pure premium. Premiums were then calculated using the following components:

- The pure premium
- 20% for administrative costs
- 5% for commissions
- 5% for losses
- No reserves or mark up.

These percentages were calculated against the total premium, not simply the pure premium.

The premium calculations, however, assumed a minimum pool of five thousand individuals. Currently, however, the scheme has only six hundred insured individuals. Basic operational costs have been covered out of the scheme director's personal resources. All three full time staff members work on a more or less volunteer basis for now.

Basing product price on how many clients you *hope* to have can be dangerous. Never count your chickens before they hatch!

Since establishment of the scheme, utilisation costs have been much higher than projected. This has led to a premium review at the end of year one that resulted in a significant increase for the second year based on a review of treatment costs for the entire year, compared with the number of visits for the entire year for each module.

	Year One premiums		**Year Two premiums**	
	Tshs	**US$**	**Tshs**	**US$**
Module 1	10,000	11	20,000	21
Module 2	30,000	32	60,000	64
Module 3	150,000	160	200,000	213

The scheme operates an entirely manual system with very few controls other than the patient ID card. Providers verify patients' identity and, as earlier mentioned, it is likely that in some instances treatment is given to imposters. ID cards have a unique number that allows validation of membership with POA, however, such validation is rarely conducted.

Providers are required to have both a lab and pharmacy within their facilities and while this is a government requirement, it exposes the scheme to risks of over-prescription and unnecessary lab tests. The scheme lacks a system for verifying that lab tests were actually carried out and providers have incentive to prescribe more expensive drugs even when cheaper drugs could have been equally effective. These issues have been discussed in meetings with providers but adequate controls still have not been put in place. The scheme is understaffed and the scheme's director, who is also the only person on staff with medical skills, is not able to carry out clinical reviews. Patients with chronic illnesses have both their consultation and drug costs covered and the lack of a co-payment has resulted in significant abuse of insurance coverage by scheme members.

Providers do not have agreed price ranges within which to operate and even the existing agreement between them and the scheme has been very loosely binding. The scheme's product is delivered through three modules with the first module entitling policyholders to only basic out-patient care. In some instances, providers have admitted Module One policyholders or referred them to expensive specialists at the scheme's expense. Rather than rejecting the claims, however, POA pays them, which only has the result of promoting further abuses. This lack of controls has resulted in a very quick build up of medical costs. It is evident that the scheme's management needs to put in place clear guidelines for treating policyholders under the different modules and to insist that providers take the risk/loss in instances where they breach the agreement. Even if they simply enforced the controls that they do have, there would be improvement.

Accounting:
Because of its severe financial constraints and inability to pay even the most basic costs, the scheme's financial manager is over-stretched. He not only carries out the accounting function of the scheme but also is also responsible for many additional activities including:

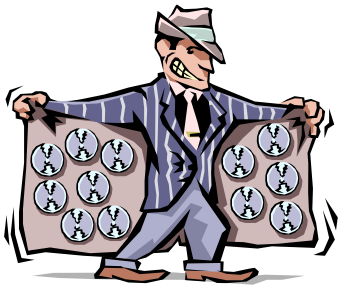
- following up expiring policyholders to re-market the product to them
- conducting administrative work within the office
- fundraising for the general health program
- receiving and handling inquiries from would-be clients
- reviewing claims
- settling disputes with providers, and
- carrying out spot checks on providers

Because of the multiplicity of roles he carries out, the finance manager is only in the office in the afternoon and, even then, his time is split across a range of demands. As a result, he has only managed basic bookkeeping for the scheme for the first five months of the scheme's operations. The scheme has no financial statements and while the finance manager tries to track claims received and premiums collected, even that cannot be efficiently done because of delays in receipt of invoices. The scheme accounting system is entirely manual with no management accounting whatsoever.

Marketing:
Marketing is purely commission-based. The scheme has no full time marketing staff. However, full time staff do provide back up support to the marketers in making a sale. Initially, the scheme recruited close to thirty volunteer marketers. Individuals were recruited purely on the basis of their *availability* to market the product. All marketers were given an initial training regarding how the product worked and how to market it. However, marketing professionals did not conduct the initial training and the scheme soon began to realise the inadequacy of this approach. Some individuals lacked the capacity to become successful marketers. It became evident quickly that availability was not sufficient grounds for the recruitment of a quality marketing staff.

Marketers met with the director for weekly feedback sessions. These meetings also served as an opportunity to monitor the content of marketers' communication. Marketers were sent out with brochures. However, even then, there were instances of misinformation by marketers and clients came to purchase coverage with different expectations. Sometimes, marketers arranged for an additional meeting between POA staff and the potential clients and this served to clarify issues for clients. However, the scheme never developed a standardised marketing approach and the content of each sales discussion was left up to the ingenuity of each marketer. For the institution this meant that there is no way of telling which marketing approach was used, and therefore the management could not identify the most effective marketing approach.

After several meetings at which most of the marketers had nothing to show for their efforts, the sales-force slowly began to dwindle. Additionally, management became dissatisfied with these unfruitful feedback sessions and, with time, they were discontinued rather than developing them into an effective management tool. As a result, the scheme now lacks a mechanism for tracking marketer activities and monitoring the content of their communication.



Effective sales requires a marketing plan, training, and incentives for sales agents. Without these factors, marketers will be no more successful than street hawkers.

At a minimum, marketers expected transport money but the institution did not have the funding to reimburse their transport expenses. As of July 2002, only three of the original thirty marketers were left. They continue to operate on a commission basis and earn 5% of the gross premium on every policy they sell. Each marketer's identification number is indicated on the client's application form for purposes of tracking the origin of each sale.

The scheme received plenty of free TV and newspaper coverage during their opening. However, since then marketing has been left entirely to the marketers who conduct marketing activities at their discretion. Scheme management recognises the need for a massive education campaign directed at the target market and is looking into ways of raising funds for this training. In addition, management is refocusing to market the product through community leaders who will also work on a commission basis. Currently, some community leaders and other members promote the product on their own initiative. The scheme is also looking into using professional insurance brokers to market the product and an agreement has just been concluded with one.

Overall:
The scheme is still very young and is undergoing an expensive learning process. Already, the scheme is experiencing very serious problems with covering claims and there is no clear source of funding to underwrite losses incurred in the past year.

Some ratios calculated during the visit include:

- Insured to staff as at June 2002: 100 insured per staff member (inclusive of marketers): 600/6
- Administrative expenses to Premiums: Admin is budgeted at 25% of premiums collected (inclusive of commissions). However, this assumes a minimum pool size of 5,000. So far, all premiums collected have been channelled into covering treatment costs.
- Dropout rate: Out of the 57 people whose coverage had expired by June 30th, 30 of them have renewed representing a renewal rate of 52%. The institution admits that the 30 renewals occurred without any follow-up or re-marketing efforts on their part and in spite of a 100% increase in premiums.
- Claims to Premiums: In the period January to June 2002, premiums collected amounted to Tshs2.2 million (US$2,340). Claims received for the same period amounted to

Tshs10.4 million (US$11,060). On a cash basis, claims were 470% of premiums. Given this experience, it is unlikely that the 100% increase in premiums will have much impact on the financial situation of the organisation. Even a doubling of the premiums would not have covered half of the claims costs and they would still be without funds for operations.

- Change in premiums written: Not enough year-to-year data was available for calculation.
- Days of unpaid claims: This was not calculable due to data limitations. Anecdotally, one of the providers had received two instalments in the one year that the facility had provided healthcare to the scheme's members.
- Reserves to claims: The scheme has no reserves in place and is actively trying to raise funds to underwrite its losses for the past year and pay the providers.

Likelihood of Sustainability:

The scheme is facing grave problems and its likelihood of reaching sustainability is seriously questionable. Premiums have only covered 20% of the cost of members' care, and the limited permanent staff are volunteering. Commission-based sales people cannot be very incentivised when from inception they have only managed to generate six hundred members. Controls are weak to begin with and the controls that are in place are not enforced. There were no reserves and no significant donor funding. Doctors are abusing the system and POA management have little ability to stop it.

There was significant adverse selection in the first year. The scheme required at least five members to join from each family, but management did not enforce the policy and some families enrolled smaller numbers intending to only insure their ill members. Thus, many of these first members were sickly. There are still no controls in place to prevent adverse selection on the family level.

Where companies enrolled their staff, some employees regarded the insurance coverage as an opportunity to access free healthcare (which it was). Utilisation levels therefore appear to be higher than initially projected. As a result, medical costs have built up very quickly. Compounding this problem, although health insurers often exclude coverage of chronic illnesses, POA specifically includes such coverage. Thus, the continual cost of consultation, tests, and medication for patients with chronic illnesses is borne by the scheme.

The scheme has no reserves and can expect no financial assistance from POA NGO since they have no resources to underwrite these losses. The scheme's management is therefore searching for potential funding sources and has sent proposals to some donors who have been known to be interested in financing health interventions. Management notes that the ILO has expressed interest in intervening with maternity cover. However, other than that possibility, there seems to be no clear source of funds to offset the losses.

Pricing of the product was based on projections of much lower utilisation and while the pricing has been revised, the viability of the new pricing structure has not been tested. Growth has been, and still is, low because of the market's lack of understanding of insurance and the stiff competition for corporate employees. The idea of health insurance is still very new to the scheme's target market. Many of them have heard of insurance with regard to other purposes though do not understand why they should pay for a service they are not sure they will receive. Such potential clients require much promotion and sensitisation. However, the scheme has not yet developed an adequate marketing strategy and the tools to implement it.

Because POA has been so slow with payments, it is likely that physicians will soon begin to stop servicing POA members. Once this occurs, and paid members are not serviced, it will be extremely difficult to build the program.

MANAGEMENT AND GOVERNANCE

The scheme Director is a medical doctor with over twenty years of practice in Britain in addition to several years as a regional medical superintendent in Tanzania. The Director appears to have good knowledge of the medical sector in Tanzania. The Resource Mobilisation Manager lived in Germany for over twenty years and has a wide network of contacts in Tanzania. While the scheme's management seems competent, but their effectiveness is constrained by the array of responsibilities that each one of them manages, coupled with a lack of resources.

One of the scheme's biggest assets is a committed team of staff who have worked without pay for the entire first year of the scheme's operations. The scheme's Director not only invested a significant amount of personal resources into the establishment of the scheme, but also continues to personally subsidise the scheme's operations.

The scheme has a nine member Board that was nominated by the POA Executive Council in May 2002. These include, among others:

- ✓ the current scheme director (who acts as secretary to the Board)
- ✓ one other private practice physician
- ✓ a representative from POA (the NGO).

Neither the Board nor management team members had any previous experience with insurance or the management of a health insurance scheme. However, the scheme's Director carried out extensive consultations with the International Labour Organisation, Partners for Health Reform, and the Community Health Fund before establishing the scheme. The Director also continues to actively seek learning opportunities through forums that bring together microinsurance practitioners.

PROVIDER PARTNERSHIPS

The microinsurance scheme's partners are primarily healthcare providers. Initially, there was an expectation of partnering with the POA Credit Shops but this has not happened. The relationships with all but one provider were initiated by POA. In the instances where the relationship was initiated by POA, the scheme did most of the marketing. In these cases providers occasionally voluntarily marketed the product to patients who seemed to have difficulty settling medical bills, and to businesses with several employees. However, in the one instance where a provider initiated the relationship, this provider has also taken on the responsibility of marketing the product.

The scheme has two types of partners, associates and affiliates. The relationship with associates is only loosely binding. However, affiliates are required to apply for membership and to undergo an inspection by the scheme's Director to certify that they are fit to be affiliated with the scheme. Affiliates also pay an initial fee of Tshs300,000 (US$ 319). The investment may have an impact in generating "ownership" of the scheme among the participating physicians. However, it appears to have had two unintended results:

1. There appears to have been an adverse selection of providers, given reluctance on the part of the market to try out this new insurance scheme, and thus only those physicians with problems appear to have joined / invested.
2. This mechanism also appears to have enhanced the need of providers to obtain a return on their investment leading to inflating billing, excess testing and over-prescriptions. Certainly we see this in other programs, however, it appeared much more prevalent with POA.

Most of the scheme's partners are affiliates and for them, entry into the relationship is an investment from which they expect returns. Because of their investment, they have a stake in the scheme's operations. Thus, affiliates were involved in the design and pricing of the product, and growth projections were jointly calculated (extremely optimistically). As a result, providers had significant income expectations. However, by the end of June 2002, the health scheme had only 600 members. 150 of these were from the Musoma region and the rest (only 350) were from Dar es Salaam and spread across eighteen affiliates. On average, this leaves only nineteen clients for each affiliate.

We visited one of the eighteen providers in Dar es Salaam for this study. This provider was one of the medium-sized partners and received on average seven insured patients per week in addition to 210 or so uninsured patients, or about 3% of its business came from the scheme. The management of the facility has much higher expectations with regard to volume of insured clients though these expectations have not been quantified. In a bid to increase the number of insured patients, the facility's staff has been marketing the product themselves. Many of the newly insured patients who come to this facility are previous customers, thus insurance is not bringing new patients but is adjusting the payment mechanisms for current patients. In the one year that this facility has provided healthcare to insured patients, it had received only two instalment payments from POA. The value of these instalments versus total claims submitted was not available.

Providers send in their invoices monthly and management of the visited facility indicated that bills are submitted within a week of each month's end. Size and frequency of payment continue to be issues to the providers though many of them are willing to be patient and to continue to provide healthcare to insured patients – a sign of the good relationship that still exists between them and the insurance scheme, primarily as a result of the personal relationships with the Director.

There is a documented memorandum of understanding between each of the providers and POA. However, the agreement has many loopholes and does not adequately define treatment protocols and pricing issues.

The scheme's management is concerned that some of the providers request unnecessary tests and tend to over-prescribe and inflate treatment costs. These issues have been discussed in one of the partnership meetings and POA management notes, "there seems to be a decrease in these tendencies."

Management of the visited facility indicated that both insured and uninsured patients receive the same quality of healthcare and insured patients do not seem to expect to be treated differently. The facility has twelve admission beds though on average only four of these are in use at any given time. Only one insured patient had been admitted in the entire year and while the scheme is concerned about over-utilisation, the impression of the health facility's management is that there isn't significant difference in utilisation patterns by insured and un-insured patients.

Providers feel that there is need for more aggressive marketing in order to increase the size of the risk pool and reduce risk to the scheme. In addition, since most of the providers made a significant initial investment that was based on certain promises (growth to reach 100,000 people in a year, for example), they are concerned about recouping this investment.

The table below summarises the comments of providers with regards to the relationship between them and Poverty Africa.

	PROVIDERS
Objectives and Expectations	▪ Increased business (volume not quantified) ▪ Improve the method of payment from patients ▪ Obtain a large return on their investment based on being on the POA providers list
Relationship	▪ Relationship was initially good but has begun to become strained as a result of payment delays ▪ Initially there was agreement to meet monthly but this has not happened. There have been four meetings between providers and scheme management over the past one year ▪ The relationship with the scheme manager appears to be keeping the provider as part of the program (plus the fact that volumes are not particularly significant, and thus the losses are limited)
Partner Role	▪ Provide necessary consultation, diagnosis and treatment ▪ Compliance with memorandum of understanding ▪ Timely presentation of claims ▪ Accurate and timely invoicing
POA role	▪ Marketing ▪ Timely payment of claims ▪ Premium setting ▪ Underwriting ▪ Maintaining reserves
Capacity Demands	▪ Minimal impact of the program on facility operations thus far ▪ Facilities have significant capacity to absorb many additional patients

LEVELS OF CLIENT SATISFACTION WITH THE PRODUCT

Three groups, with a total of twenty people from different areas around Dar es Salaam, contributed in Participatory Rapid Appraisal group discussions. These groups were comprised of clients who had purchased Modules One and Two. Module Three has very limited subscription, and none of the insured at that level were available for such discussions.

General Impressions:

In general, respondents were happy with the premiums, which they found to be affordable. They also appreciated the freedom to choose their primary health care provider (within the list). This gave clients an opportunity to choose a provider who meets their needs in terms of location of service and quality. However, clients were not happy with the limited and conflicting information communicated to the clients by POA. They noted that communication was insufficient, unclear, and confusing. None of the respondents at Sinza, for example, were aware that in-patient care was not included in the module they had purchased (Module One). Members had no issues with the requirement to fully pay for the coverage in advance.

> "*I recall that when my son was sick two years ago, my bank account had a balance of Tshs 40,000 (US$43). I was forced to withdraw Tshs 30,000 (US$32); the bank requires a minimum balance of Tshs 10,000 (US$11). He had severe malaria and anaemia, Tshs 30,000 was not sufficient, and I had to borrow money from friends and relatives. When my son recovered, I had a debt of Tshs 150,000 (US$160). After his recovery, I had to sell my television set to pay the debts. I think now I feel secure since I can minimise the chances of my children being admitted by reporting to the health provider as a disease strikes rather than spending a lot of time looking for money*."

Quality of Health Care Services:
The respondents were mixed in their comments about the quality of services offered. Some of the respondents were accessing health care from a well-known health provider, Kinodnoni Hospital. These respondents had been accessing the services from this provider before they joined the Poverty Africa Program. However, some respondents cited the following problems regarding quality of health care:

- Some health care providers do not have an adequate supply of drugs. This forces a holder to buy from a drug store out of their own funds.
- Sometimes care of POA members is delayed in favour of others
- Some health care providers have unqualified and/or demoralised staff

The respondents had the view that some health providers are justified in behaving badly because Poverty Africa does not pay them in time. Clients are unhappy when they receive complaints from health care providers about the delay in payment of bills by Poverty Africa since they pay their premiums in full before accessing services.

Client concerns:
Sustainability: Policyholders were concerned about the sustainability of the program. This arose out of worries created by Poverty Africa's delay in paying bills to health care providers. Participants also raised a concern about what will happen to them, and their health insurance policies, in the event that Poverty Africa runs into financial crisis. They wanted to know if the Government is a part of the program or if some other donor is well positioned to rescue the situation. Perceptions of impending crisis will likely have a strong negative impact on renewals as well as making it difficult to grow the numbers of insured.

Program promotion and concept of insurance: Clients raised concerns that the program was not known in their communities because they felt that Poverty Africa had not done sufficient work to promote the program. Clients believe that high outreach will generate sufficient income and that maybe POA's ability and willingness to pay Health Care providers will improve.

> "*It is very difficult these days to get assistance for treatment. If you do not have the money, you will just be left to die. With death, people can easily assist you, but not [with] sickness. Sickness is for you and your family"*

RISK MANAGEMENT
POA management exhibits limited knowledge of the controls required for proper health insurance provision and the institution lacks many of the required basic control systems. Even where POA has stated controls, these are often not enforced. Because of this, POA is significantly exposed to, and has suffered from, several risk related problems that have led to financial losses. Appendix 1: Managing Insurance Risks: Strategies used by POA's Health Insurance Scheme, notes common risk mitigation techniques for such a program and how (or if) POA applies them.

Risks to Partners:
With this program, providers have taken on significant risk in two areas: investment risk and credit risk. In order to access the insurance program, providers have paid an initial capital investment to POA. Their assumption was that they would make a return on that investment though the promised volumes of clients that they would receive. Because the POA insured

population is 0.6% of that anticipated, it is unlikely that any significant return will be realised. Even recouping the original investment will be difficult if not impossible.

Providers also suffer from credit risk through the provision of services based on the assumption of payment by POA. Payment of invoices by POA has been very slow. The scheme's lack of controls (which have been abused by several physicians) coupled with the absence of reserves to cushion losses makes it appear highly likely that providers will not be fully paid.

The significant delays in claims processing by POA have created cash flow problems for providers as well. Three providers threatened to discontinue treatment for scheme members but have been persuaded to continue to allow access to treatment. The scheme has negotiated a blanket 40% reduction on all outstanding claims. This is primarily to offset costs resulting from inflated bills by some of the providers. For providers who were not inflating bills, this 40% represents a direct loss and an incentive to inflate future invoices. Even after this reduction, providers are still owed significant amounts by the scheme. At the time of the visit, POA was unable to provide any details on the total outstanding claims.

Still and all, POA management remains optimistic that their fundraising efforts will yield adequate funds to settle all the outstanding claims, however there is no guarantee that this will actually happen.

SWOT ANALYSIS
A SWOT analysis table is provided in Appendix 2.

PRODUCT
While it is important for an insurance product to be comprehensive, the degree of coverage of POA's product is such that it compromises the program's likelihood of reaching sustainability. The lack of exclusions and limitations is a major weakness, resulting in over-utilisation and high losses. The lack of controls at the delivery points exposes the program to fraud and claims inflation by providers. However, with the appropriate controls in place, and proper pricing of its premiums, the program has a potentially attractive product.

The three-module approach is attractive as well. However, the third, most comprehensive module, is bound to attract adversely selected people since the only additional benefit it offers is that of complicated surgery.

OPERATIONS
The program relies very strongly on provider staff to administer and control the product. This reduces POA administrative costs significantly in that the program does not have to invest in staff and infrastructure at each provider facility. However, without the appropriate controls on the provider, this approach exposes the program to additional risk. Leaving the significant controls in the hands of the party who is providing the service is a prescription for fraud in almost any business. There are no written policies or procedures manuals to offer operational guidance to the providers or POA staff.

A highly committed physician manages the program and thus there should be capacity to conduct clinical reviews, but he is overwhelmed with other activities.

MARKETING
Management believes its approach to marketing to be cost effective. Costs (in the form of commissions) are incurred only against actual income, thus the scheme does not incur costs when there is no effective marketing output. However, the effectiveness of current marketing

efforts is impeded by the market's lack of understanding of the concept of risk pooling. The scheme's management recognises that in order for their marketing efforts to yield better results, they need to be preceded by a large educational campaign to enhance the market's understanding of risk pooling. Management has been unable to develop such a campaign.

It is clear that better selection and preparation of marketers is necessary to minimise the potential of misinformation in the market due to poorly skilled marketers. Certainly, these marketers have the strong incentive to sell the policies. However, the most lucrative market for insurance is among those that are sickly. Thus, the institution's lack of controls over adverse selection (at least in terms of individual policies) enhances the ability of marketers to earn money while damaging the potential sustainability of the institution. The current focus on insuring low-income employee groups should help to mitigate this problem.

ACCOUNTING

The scheme's accounts have not been produced in an accurate and timely manner. The books are currently behind by about ten months. No management accounting is performed since accounts that are this old are almost useless to the management of the institution. This is a serious issue with this program.

RISK MANAGEMENT

As earlier mentioned, the scheme's controls are weak and leave the scheme exposed to over-utilisation, cost escalation, moral hazard, adverse selection, and fraud. Product delivery systems, product components, operational processes, and indeed the entire control structure of the institution needs to be reviewed. However, even after possible adjustments, the critical factor will be management's effectiveness in enforcing new policies and structures. Historically, management has shown laxity in requiring compliance.

LESSONS LEARNED

Operations:

- Potential **health insurance providers without adequate capital and capacity** should not even enter into the business of health care financing. POA began providing health insurance with no reserves, poor controls, and limited management knowledge of the insurance business.[3] Today, the scheme is faced with the challenge of finding resources to cover even their historical losses. There is very limited likelihood that these resources will be obtained and the risk could very well end up being absorbed by POA's other programs, their pool of health care providers, and the premium payers.
- POA, with its affiliates, carried out their own initial risk assessment and set their pricing based upon their assessment of the risks involved in serving their selected market, coupled with their growth projections. A year later, the scheme has incurred high losses and lacks the resources to underwrite these losses. **Risk assessment by the unqualified can result in a financial disaster**.
- Microinsurance program **design must include significant controls** to deter moral hazard, adverse selection, over-utilisation, and fraud by providers and the insured. In one year of operations, POA has suffered heavy losses and is now highly indebted to its healthcare providers primarily because controls were, and remain, either absent or unenforced.

Marketing:

- While commission-based marketing has the benefit of cutting down on costs, **not every available and willing person can make a successful marketer**. POA has very quickly learned this lesson. Out of an initial thirty marketers, only three have been productive and

[3] Management notes that what knowledge they did have about insurance operations was gained through attendance at ILO microinsurance meetings and courses, among other initiatives.

even the performance of these falls well below management's expectations. This indicates the need to set targets and to ensure professionalism and capability even with marketing agents who are entirely commission based.

- Among the twenty-five affiliate providers, the most successful at marketing the product was the one affiliate that initiated the relationship with POA rather than the reverse, as was done for every other affiliate. When the **physician drove the relationship** with POA, there was much more enthusiasm in marketing the product to clients.
- Since health care providers offer services of different qualities, **personal choice of which services to access is critical**. This is true both in terms of helping insured to match their needs, and in maintaining market pressures on the provider to offer top quality service. Assigning insured clients to a single provider allowed for a lesser quality of care provision due to the captive nature of the provider / patient relationship.
- **Low-income employees can be a good market for health microinsurance.** The majority of Poverty Africa's clients are low-income employees of private and public companies. Employers have noted that the microinsurance program provides a cost effective means of covering the health care needs of their low-income employees. POA notes the improved efficiency of working with such organisations in terms of marketing and obtaining premiums from a single source.
- Insured clients are confused about the terms of their policies, partly because of the limited tools of the marketers. Ideally, the program could **produce consistent presentation materials** for marketers, as well as pamphlets, or even brief summary policy information at the back of the identity card.

Accounts:

- **Control of the institution is lost** when the accounts department is weak. With POA, accounts have not been prepared for almost one year. No operational results are reviewed, and management decision-making cannot be based on the realistic position of the institution.

Provider partners:

- Even where very warm relationships exist between insurers and other partners, there is need to **formalise these relationships and to set down clear guidelines** in order to prevent unnecessary exposure to risk for the parties involved. While POA's relationship with its providers was formalised through memoranda of understanding, the agreement lacked clear guidelines or defined responsibilities for each party. As a result, providers frequently inflate costs or give patients treatment that is beyond the limits of the cover they have purchased. Providers, on the other hand, have no certainty with regard to when their outstanding claims will be settled.
- The due diligence that one would expect in a relationship between health care providers and the insurer was absent in the case of POA. Although there was an initial attempt by POA to select providers based on set criteria, this was abandoned when there was little interest shown by providers. This lack of interest may have resulted from POA failing the due diligence tests of the better providers (however informal this testing may have been). This has led to acceptance of several lower quality providers. **Maintaining due diligence criteria is important** to the success of a health microinsurance program.
- The investment requirement of providers is innovative, but there is insufficient evidence to draw conclusions about this practice from the POA experience. What does seem clear is that **some providers are using fraud in an attempt to recoup their investment**.

Appendix 1: Managing Insurance Risks: Strategies used by POA's Health Insurance Scheme

Risk:	General Strategy:	Specific Strategy:
Moral Hazard	Pre-selected providers	Work with a network of twenty-five providers in Dar es Salaam, Dodoma, Mara, Mwanza and the coast region
	Claims limits	None
	Co-Payments	None
	Loss review	Has been carried out once since program inception and this resulted in a review of premiums
	Exclusions	Module One excludes in-patient cover and all types of surgery
		Module Two excludes only complicated surgeries
	Waiting periods	Approximately one month from premium payment while awaiting the ID card
	Proof of event	Not required. Claims payment is based solely on the submission of an invoice by the provider
	Client identification	Each client must present POA ID in order to receive treatment. Providers who have incentive to treat more patients with insurance coverage conduct verification of patient identity. At the same time, there is evidence of providers charging POA for care of uninsured patients.
	Pre-approval of treatment	Patients must undergo consultation first in order to obtain any drugs
	Expense verification	Minimal, only done when bills appear "unrealistic"
	Deductibles	None
	Initial exams	None required, though insured are entitled to an initial exam upon enrolling. This is not used as either a control or pricing mechanism by POA.
	Use of pre-existing groups	POA works with pre-existing groups, including employee groups, as well as random families.
	Prerequisites to care	None
	Membership from existing groups only	Not necessarily, and within groups there is no minimum percentage of purchasers required.
Adverse Selection	Whole family membership required	Not required. Primary insured chooses some or all family members depending on their assessment of the individual's need for coverage.
	Required membership within groups	Any number can join
	Defined risk pools	None
	Waiting periods	Delay in provision of ID card effectively creates a waiting period. However, some adversely selected people will immediately enter the hospital requesting the hospital to confirm payment with POA. POA does provide confirmation in such cases.
	Tying insurance to other products	There is no linkage between the insurance and any other product of POA.
	Periodic cost evaluation	Costs were evaluated at end of the first year of operations, and this resulted in a premium review. However, the new premium is clearly far from satisfying the financial needs of the scheme.
Cost escalation	Preset pricing agreements with providers	Discussed verbally with providers but conclusions were not documented. POA management suspects rampant over-billing
	Preset drugs list	Discussed verbally with providers but not documented. Thus, medication choice is left to the providers' discretion, and management notes this is often abused
	Co-payments	None
Fraud and Abuse	Computerised ID systems	The system is completely manual
	Coverage limits	None
	Physical identification	The identification card has a photo of the insured and treatment is supposed to be given only to individual in photo on ID card, however, this is policed by the provider who has incentive to cheat.

Appendix 2: SWOT Analysis

Poverty Africa Insurance Scheme: Institutional SWOT Analysis			
STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS**
	PRODUCT		
Flexible product (three modular options)	No limitations or exclusions, institution left exposed to risk, pricing is inadequate to support this leve of comprehensive cover	Program only has 600 insured thus significant changes will impact only these relatively few insured	Poverty Africa is developing a negative reputation in the market because of problems with this scheme.
	Care is provided by lesser quality providers	Private physicians are generally interested in relationships with quality insurers in TZ due to high competition	Inability to pay claims will make it more difficult to interest quality providers
	OPERATIONS		
A network of willing providers who are patient with the institution in spite of payment delays	Severe losses are not covered by reserves or any other source.	Other providers have high pricing. If scheme stabilised, it could potentially be very competitive	Questionable quality of service from some of the providers likely to result in loss of business
Good relationships with providers	Lack of controls jeopardises the likelihood that the scheme will ever reach sustainability	Limited competition for low-income earners' in most markets.	
	MARKETING		
Entirely commission based marketing approach that cuts out unnecessary expenses on unproductive marketing activities	Lack of resources to carry out the educational marketing that needs to precede the sale in order to increase certainty of making a sale	Large growth potential without added cost since agents only get paid for business they bring in	Incentives of marketers must be controlled since their interest in strictly in bringing in numbers, with no consideration of adverse selection
	Marketing tools to ensure consistancy of message have not been developed	Huge potential market for a well-run microinsurance organisation	Product confusion is leading to misinformation in the market
	ACCOUNTING		
	Management decisions are made without the benefit of financial data		The institution is in severe trouble, and they do not even understand their situation
	Accounts are almost one year behind, and there is no management accounting function or data		Even their clients are vocal about concerns for the organisation's sustainability
	RISK MANAGEMENT		
	Controls are weak and limited, and existing controls are not consistently observed.	There is information available on controls for microinsurance institutions.	Even short term viability is uncertain because of lack of reserves, high losses, and continuing high claims to premium ratios
	Lack of controls against cost escalation and over utilisation jeopardising viability of operations		The institution is seen as easy to cheat because of its weak controls

Appendix 3: Patient Flow at Hospital: