"Creating partnerships to insure the World's Poor"

Kitovu Patients Pre-Payment Scheme

(Kitovu Hospital, Masaka, Uganda)

Notes from a visit 27-28 June 2002

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

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27 November 2002
Version 3.6

INTRODUCTION AND BACKGROUND[1]

Kitovu Patients' Pre payment Scheme (KPPS) is a hospital-based model of health care provision operating in Masaka, Uganda. The concept to establish a health care prepayment scheme within the hospital was championed by the Medical Missionaries of Mary who were in charge of the hospital at that time. Their objective was to establish a prepayment scheme as a way of enabling low income families in the hospital's catchment area to access quality medical care while increasing utilisation of the hospital without increasing collection difficulties. The hospital oversees the program, absorbs the insurance risk, and indeed manages the Scheme as a cost centre under the Kitovu Hospital Complex.

The scheme commenced in 1998 with funding from the British Department for International Development (DFID, and by mid-1999, minimal growth had been achieved. There followed a period of review in which expansion was curtailed as the hospital management sought to make a decision about the future of the scheme. It was also during this time that hospital management was working towards a full-scale handover of the hospital from the Medical Missionaries of Mary[2] to the Daughters of Mary, and local catholic Sisterhood. This pending transfer, concluded in December 2001, created some concern by management of the fledgling scheme regarding its, and their, future. After the transfer, hospital management in fact has left the scheme outside the mainstream issues that became their focus.

In October 1999, the hospital management decided to resume the scheme under a new manager. There was better growth during 2000 and by the last quarter of that year, the scheme had grown to about 1,200 members. Though no quantitative growth objectives had been set, scheme management was reasonably pleased with this level of membership, though hospital management appeared not to consider this program as significant.

Members at this point were mostly microfinance borrowers from FINCA Uganda credit groups. In late 2000, FINCA returned to a strict policy of using client's savings as the basis for determining their loan eligibility without any consideration of the savings spent for the health care coverage. Previously, FINCA had allowed their clients to purchase health care financing products from their savings without penalty on future loans. The return to the strict policy of matching savings directly, resulted in massive dropouts from the KPPS with scheme membership decreasing to 600 over the subsequent four months as FINCA client's policies lapsed.

There has been slow but steady growth since then with over 1,750 members as at June 2002. Of these only 130 (or 7%) are microfinance clients while most of the others, though still low-income, are related through employment groupings. The low-income employment groups have been found to be easier to work with because employers either collect the premiums, or pay directly for all those to be covered. This has proven much more efficient than working with an MFI that makes very limited efforts to facilitate the Scheme activities among its members.

KITOVU PATIENT PRE-PAYMENT SCHEME PRODUCTS

As a hospital based program, KPPS offers products that are directly related to Kitovu Hospital services. The scheme is only available for coverage at the hospital, and at this point there are no satellite clinics. To address the issue of the distance of the hospital from the bulk of their patients, there has been discussion about opening a clinic in Masaka Town. The hospital does

[1] The authors wish to thank Joseph Kiggndu the KPPS Coordinator and well as the management and staff of Kitovu Hospital, and the Masaka office of FINCA Uganda. Without the openness and helpfulness of these people it would have been impossible to generate the data for this paper.

[2] The Medical Missionaries of Mary are a Sisterhood based in Ireland with health care related activities in sixteen countries.

have an outreach service that provides preventive and curative care off the grounds of the hospital, but there has yet been no direct linkage between this outreach program and the KPPS.

KPPS offers a comprehensive care package covering both in- and out-patient care, as well as hospital procured medications and hospital administered diagnostic tests.

Kitovu Patient's Pre-Payment Scheme Details:

PRODUCT	
Eligibility Criteria	• Potential members must be members of a pre-existing group (can be an MFI, employment, or other large formal group) • At least 60% of group must join the scheme, or the others will not be accepted • Members must have paid their premiums in full before they receive any care • Families of any size may join, but a membership in the scheme requires payment for at least four members
Coverage	• Provides for in- and out-patient cover, as well as medications and diagnostic tests
Duration of Cover	• Four months (for MFI clients) • Six or twelve months
Limitations	• In Patient Cover up to Ushs 80,000 (US$ 44.44[3]) per admission • Out patient cover up to Ushs 15,000 (US$ 8.33) per visit
Exclusions	• Optical, dental, ambulance services, open-heart surgery, referrals to other facilities, and private rooms are not covered by the scheme.
Mode of Delivery	• Health care is delivered at Kitovu Hospital. • The prepayment program is administered (marketing, servicing, premium collection) either at the workplace, or at MFI group meetings.
PRICING	
Premium	• Ushs 3,200 (US$ 1.80) per person per four months • A minimum of four persons must join with any household. Thus, the minimum premium for a household for four months is Ushs 12,800 (US$ 7.10)
Method of payment	• One lump sum at beginning of the period for MFI clients and some others. • Monthly payments for some employed. • No mechanisms for generating the premium (savings or credit) are provided except with some employer groups which hold the premium amounts from the salaries of their participating employees, and then pay the plan. • The head office of FINCA was testing a credit product for health care financing but there had been no discussion of this at the Masaka branch. • The FINCA branch was consolidating premiums paid by their clients to facilitate payment to KPPS.

[3] At the time of the visit Ushs 1800 = US$1.

Other	• Co-payment fees: o Ushs 500 (US$ 0.28) per regular business hours visit for outpatient care o Ushs 1,000 (US$ 0.56) per non-business hours out patient visit o Ushs 1,500 (US$ 0.83) per admission. • All transport and food costs are borne by the member
PLACE	
	• Health care is provided only at Kitovu Hospital, a well-regarded regional missionary referral hospital. • The hospital is located about two kilometres from the main road, and about three kilometres from the centre of town. • The KPPS office is co-located within the hospital's in-patient cashiers' office close to the outpatient department. • Premiums are collected at group meeting enhancing convenience for MFI clients. • The average cost of one way transport from town for one person was said to be Ushs 2,000 (US$ 1.11)
PROCESS	
Enrolment/Renewal	• Member pays premium and submits photograph of family members to be covered. • The member provides two photos of all those to be covered within the family o A single laminated ID card with a photo attached is produced and provided by KPPS (at no additional cost to the member). o The other photo is held by KPPS for improved identification confirmation
Receipt of Treatment[4]	• On arrival at the hospital, the member collects an Outpatient Department charge sheet[5] from the KPPS office and goes with it to the hospital cashier to make the co-payment. • The member registers and sees a physician in turn. • If lab tests are requested, the member presents the ID card and charge sheet to the lab. The lab carries out the tests and indicates the costs on the charge sheet. • If the physician prescribes medication, the member goes to the pharmacy and presents the ID card and the charge sheet • Medication costs are calculated and indicated on charge sheet • If the cost of drugs exceeds the coverage limit, the member pays the balance in cash, otherwise there is no additional payment. • The drugs are dispensed and the charge sheet is returned to the KPPS office by hospital staff at the last point the patient calls during the visit – usually the pharmacy for out-patients

[4] A detailed diagram of the process of accessing treatment is outlined in Appendix 3: Patient Flow at Hospital.
[5] All KPPS charge sheets are stamped "KPPS" to distinguish them from the numerous other charge sheets used by non-covered patients

Claims	• Claims transactions are essentially inter-company transfers between the project account and the hospital. o The cashier's office brings charge sheets directly to accounts o Accounts transfers the payment from the KPPS account to the hospital account • Claims payment does not require the approval of the KPPS manager, thus limiting the manager's ability to manage the project finances. The manager does track treatment costs against charges, but after the accounting transfer has been completed. His ability to correct payment errors is limited. • The KPPS manager reconciles these accounts about once per quarter.
PHYSICAL EVIDENCE	
	• ID card with family photo • Basic KPPS registration form • KPPS Office in the same room as inpatient check out desks • Special KPPS charge sheets
PEOPLE	
	• Check in desk person at KPPS office who crosschecks that member's policy is current and provides the charge sheet. • Marketing people from KPPS who attend MFI meetings and visit at places of employment. • The medical staff at the hospital • Volunteer "zonal managers" who promote the scheme.
PROMOTION	
	• Word of mouth by marketer, community members, zonal managers, and some MFI staff • Brochures • Visits to MFI meetings and places of employment • Distribution of subsidised mosquito nets

Prevention:
KPPS has arranged to sell mosquito nets to members at subsidised prices. Members quickly depleted inventories. No information was gathered or tracked that would help them better understand utilisation of the nets and effectiveness of the program in reducing malaria cases.

Kitovu hospital has a Community Based Health Care department operating from the hospital. This department is involved in promoting preventive activities within the communities that access the hospital. Close collaboration between this program and KPPS would promote better health within KPPS's market area and potentially result in decreased utilisation by health scheme members. Reduced utilisation by members could help improve the viability and sustainability of KPPS. Because of the structure of the hospital is it necessary for senior management to push the departments into collaboration. Although seemingly simple to initiate, and with significant benefits to both, this has not occurred.

INSTITUTIONAL STRUCTURE:
KPPS has only two staff - the project coordinator and an MIS assistant. The MIS assistant reports to the project coordinator. However, KPPS as a department lacks a clear reporting structure and operates as an orphan within the hospital. The KPPS manager is accountable to the hospital management for the activities of the scheme though there appears to be no formal program oversight. Initially, the scheme's operations were subsidized by a three-year DFID

grant supporting the Uganda Community-Based Healthcare Association. This grant also provided reserves to cover net losses due to claims. However, the grant expired in 2001, and no subsequent funding (beyond premiums) had been obtained.

The institution has funds to cover operations and anticipated claims losses until at the latest the end of the 2002 if there is no additional funding, or significant adjustment to the premium (which would certainly result in a reduction in demand).

Hospital administration does acknowledge its responsibility to provide care for the insured regardless of the position of the KPPS unit, but appears to have done nothing to either generate funds for the scheme, or adjust operations and marketing to limit their exposure. At the same time, the hospital administration is in a search for funding to keep the hospital itself operational.

The scheme coordinator is responsible for planning and raising finances for the operation of the scheme. As at the time of the visit, he had identified no likely source of external funding, and was not looking at premiums adjustments as a source that would cover these financial needs. The institution is in a rather precarious position.

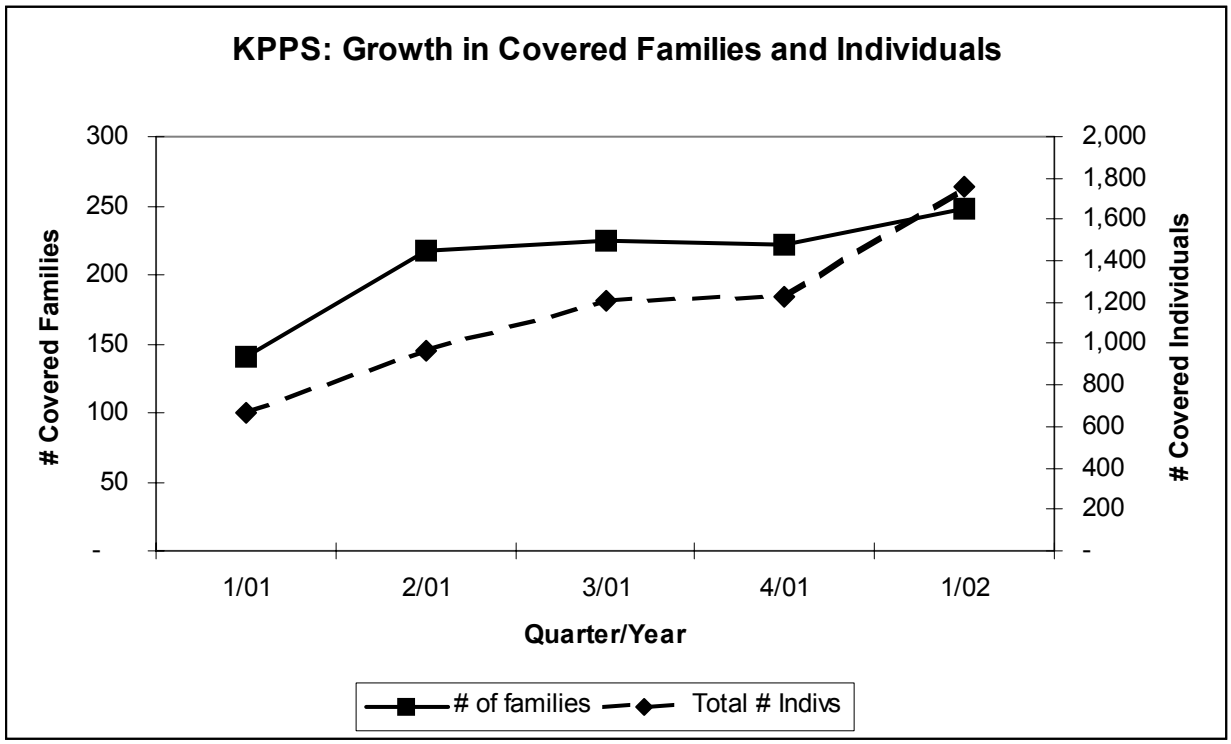
The hospital administration was completely changed in January 2002 when the Medical Missionaries of Mary completed a five-year process of handing over the hospital to the local diocese. Upon their departure a new administrator (the former Mother Superior of a convent with eighteen sisters) was selected by the diocese to run the hospital complex. She appeared to be in the process of setting her priorities for the hospital and this may significantly influence the KPPS program.

Generally, the scheme requires a representative in senior management to champion this project. The hospital is taking on significant responsibility and should have a better understanding of the operations of the organization and the responsibility it is accepting.

Health Scheme Operations:

The scheme's operations are very closely integrated with those of the rest of the hospital complex. Both in- and out-patient treatment is done by the hospital. KPPS patients receive the same treatment as all other patients. Scheme members' premiums are paid into an account managed by the hospital and the hospital accountant periodically makes information on premiums, claims, and operations costs available to the Scheme Coordinator. Treatment costs incurred by the hospital are recovered through an internal transfer from the scheme account to the hospital account initiated by the accountant. The scheme's losses for the three years through December 2001 were underwritten by a DFID grant. However, as noted above, current funds are expected to be depleted by the end of the year 2002, and any costs after that will have to be fully underwritten by the hospital.

Growth has been slow but reasonably steady for the scheme. Growth over the five quarters from January 2001 are shown in the following table:



Cost recovery rates for employed groups were considered "good" and the Scheme's Coordinator is considering recruiting an increasing number of these groups especially since they are also capable of paying higher premiums and can cross subsidise poorer groups.

As an example, Centenary Rural Development Bank staff in Masaka were covered under the KPPS. The bank paid double the standard premium and utilization was said to be less than 10%. These formal sector groups tend to be healthier, to have lower utilisation rates, to find less difficulty in raising the premiums. For these groups there is ease of premium collection and generally a better understanding of the concept of health insurance, resulting in lower follow up costs. In part, this strategy has resulted in the proportion of MFI client membership in the scheme moving from virtually 100% in 1989, to a mere seven percent in the June 2002.

Scheme management has in the past tried to put in place mechanisms to ease premium collection for community groups in order to ensure higher enrolment, however these have not been successful. They started out with a process aiding people in accumulating premiums through regular savings. However, this required collection and monitoring of the savings by the scheme management. The project lacked staff to efficiently monitor collection of premiums and this mechanism failed.

Next, the scheme designed request forms to facilitate MFI deduction of premiums from their clients' savings with the MFI, or from the loan at the start of each loan cycle. However, because the relationship was not formalised by MFI management, and formal processes were not developed for these transactions, the success of this mechanism became dependent on the goodwill of credit officers. The Credit Officers preferred to have the group members make deductions for themselves. This required the physical presence of KPPS staff at each group's disbursement to collect the premiums. This process raised security and control concerns for both the Scheme and the MFI even beyond the lack of staff resources to conduct this intensive level of follow up. The scheme now works through group leadership to collect premiums though this has not been nearly optimally effective. The scheme still needs to put in place systems to enable community groups to raise the premium efficiently and effectively.

Accounting:
The scheme does not have a separate accounting function. The hospital accounts department manages the scheme's accounts. However, because the scheme is not recognized within the hospital's institutional structure and is therefore not represented on the senior management team, no one within the hospital is responsible for actively tracking the scheme's financial performance.

The Scheme Coordinator is well aware of the scheme's financial performance in spite of the scheme's lack of independent financial statements. The Coordinator keeps track of the scheme's fixed assets and levels of premiums collected, but does not otherwise have a balance sheet. The current Scheme Coordinator has developed a simple system of accounting for income and expenditure based on the transactions that he knows (which are limited). Periodically, (usually on a quarterly basis) the Scheme Coordinator requests and obtains information on actual scheme account balances and utilization from the hospital accountant. This information is used to cross check expenditures and learn of the amounts available within the scheme's accounts. The Scheme Coordinator annually develops a budget, and on a quarterly basis carries out variance analysis based on the information provided by the hospital accountant.

The Scheme Coordinator has developed a simple but effective excel based system that is capable of producing utilization statements. These reports reflect growth for each period, income, and utilization costs for the scheme's operations and enable the calculation of basic cost recovery for each group of insured people. Management of the scheme is thus able to track key information using information provided by the accounts department, and input manual into the excel spreadsheet. This is certainly not an efficient activity and essentially requires a recently hired full-time MIS Assistant, as well as whatever human resources are required in the hospital's back office.

Marketing:
Until very recently, the project coordinator did most of the marketing for the scheme. The marketing approach relies on a strong emphasis on the benefits of insurance. In addition, the scheme has invested in cultivating the good will of potential member groups through distribution of subsidized mosquito nets to key persons within these groups.

In April 2002, the scheme co-coordinator initiated a community-based approach to marketing the product. The approach relies on opinion leaders within selected communities within the scheme's market area. This new approach is in its very preliminary stages and has yet to yield reportable results. The approach primarily focuses on recruiting pre-existing community groups through local political and opinion leaders. The merits of this approach include the fact that people of repute within the community who have had experience with the product and can testify to its benefits will market the product to communities. However, currently the role of the "opinion leaders" is purely voluntary and how much this will achieve without providing incentives is questionable.

Additionally, local political leaders can be problematic when promoting an organisation's product or service. Because health care prepayment is little understood, KPPS will need to be very careful about how these volunteers present the product. Significant training of volunteers is needed and a clear mobile marketing presentation should be developed so that the "marketers" will be telling potential members a correct and consistent story about the product.

KPPS and hospital management should seriously consider the future of KPPS. As they generate new members, they are taking on an undetermined liability for the duration of the policy. Through their marketing, they are creating a pool of risk that extends significantly beyond the life of the project funding at this point. Unless new funding is sincerely expected soon, or the institution dramatically adjusts it premiums scale (which will create additional issues for KPPS) they should be very careful about increasing their pool of insured. The hospital administration should be concerned about this, and acting towards its control.

Overall:
The KPPS was developed out of concept with support from a donor and from a different hospital management team with different objectives and priorities. The new management team is focused on other issues, the donor's participation has come to an end, and the institution is suffering monthly net losses. Without additional funding the scheme is in serious danger of closing within the next six months and the hospital will be left to make good on its commitment to treat those it has insured.

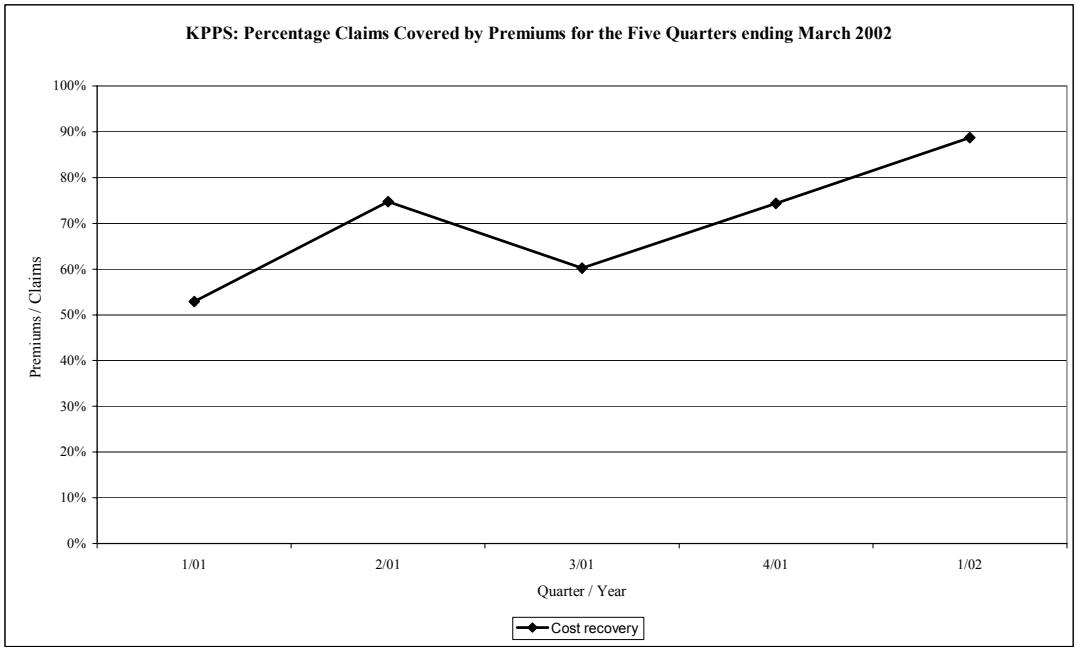
Some ratios calculated during the visit include:

- Insured to staff as at end of March 2002 was 878 (1,756/2). This relatively high level of efficiency is partly attributed to the recruitment of entire institutions into the scheme
- Admin to Premiums: 78% (exclusive of the cost of nets)
- Dropout rate: 6.2% for the first quarter 2002. This low level of drop out is a result of having predominantly low-income institutional employees as members who were still within their one-year coverage period. Most of the MFI clients had previously dropped out in the 2001 when their institution revisited some of their policies.
- Claims to Premiums: Premiums collected for the period January to March 2002 covered 89% of the claims made for the same period.
- Change in premiums written: 11% [6]Member utilisation: Out patient services: 1.65 OPD visits per year per person (with an average of Ushs 5,500 (US$ 3.10) per out-patient visit)In-patient services: 0.12 admissions per year per person (with an average of Ushs 32,500 (US$ 18.10) per admission)Days of unpaid claims: None because the claims are paid directly from the scheme's premiums account by the hospital accounts department.
- Reserves to claims: the scheme currently has no reserves

[6] Change in Premiums = total premiums current period less total premiums prior period/total premiums prior period

Likelihood of Sustainability:

At its best, over the five quarters ending March 2002 premiums covered 89% of the claims. As shown in the chart below (KPPS: Percentage claims covered by premiums for the five quarters ended March 2002) there has been a reasonably consistent improvement during this period.



However, sustainability requires not just coverage of claims, but also coverage of administrative expenses, an addition to a reserve account, and some surplus. Given the values shown above, we can estimate that the total cost of the operations is actually just over 200% of the premium income. The details of the costing estimate are shown in the table below.

Premium Component:	% Component to current premium
Claims to premiums	113%
Administrative costs	78%
Reasonable addition to reserve	5%
Reasonable addition to surplus	5%
Components to current premiums	201%

The scheme has suffered from adverse selection with the MFIs, because uptake requirements were reduced in order to generate membership. Additionally, managing the relationships with MFIs and their customers was found to be labour intensive, with limited results, so now they concentrating more on enrolling lower risk groups that also have the ability to pay higher premiums. These are low wage employees. This market is still largely untapped for health care financing with significant stated demand. With time, the scheme could become sustainable using this strategy. However, the scheme currently lacks the capacity to tap significantly into this market. The scheme coordinator notes that he is already over-stretched, thus it is unlikely that he will realise significant additional growth on his own.

The project has limited capacity to manage a large influx of new members, and without large volumes, it is unlikely to reach sustainability. In the very short term, there is a need for capital to continue in terms of both coverage of losses, and operations costs. The likelihood of donor

funding within the needed time is somewhat unlikely. Further hindering potential funding is the fact that all the institutions in the DFID funded project are in the same position, and they too will be looking for donor assistance.

Should the project obtain funds, their long-term sustainability will remain questionable unless they address a number of significant issues as discussed below, including:

- capacity on insurance technical issues
- support from the hospital
- ability to assess risk
- professionalizing pricing calculation and implementation
- financial controls, and
- marketing, and
- quality of service at the hospital
- operational profitability

Without addressing these issues, sustainability is likely to remain elusive for KPPS.

MANAGEMENT AND GOVERNANCE

KPPS relies significantly on the Uganda Community-Based Health Financing Association (UCBHFA)[7] for strategic level decision-making and oversight in terms of the health care financing product and its administration. The UCBHFA provides, among other things, technical assistance to their members in an effort to improve the efficiency of assistance delivery.

The scheme is neither represented on the senior management team, nor is it part of the formal organisational structure of the hospital. The scheme has an innovative manager. However, he lacks a management team to consult with regarding the operations of the scheme. Additionally, the scheme lacks a top management representative within the hospital to convey its interests and needs in the decision-making processes, and to ensure that the scheme is integrated into the functioning of the hospital.

Partly due to the total change in hospital management, there is a general lack of ownership with regard to the scheme. The new management seems to have a limited understanding of the potential contribution of the scheme to the overall goals of the hospital complex. This would likely be improved with a more formal governance structure.

PARTNERSHIPS

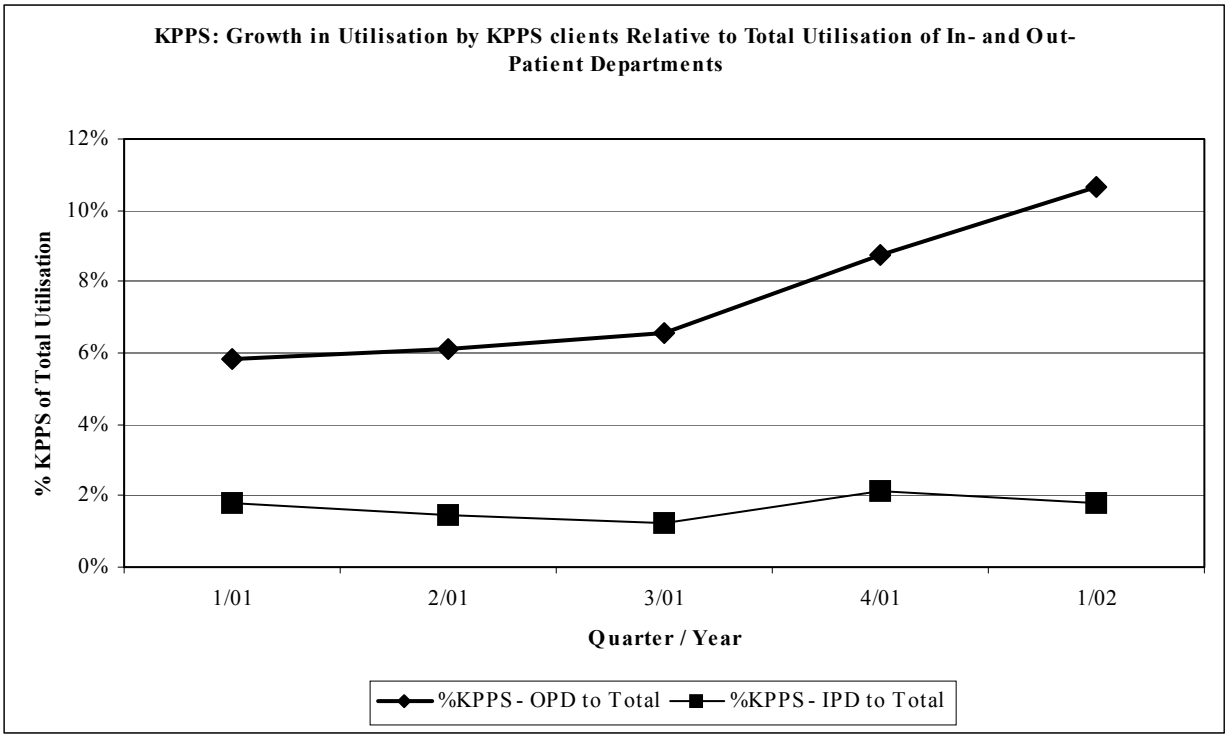
This hospital based, and the hospital management's expectations in initiating the scheme were that it would increase

- The volume of prepaid care, and
- Access to good quality healthcare for the communities at a price they could afford.

However, these expectations have only been partially realised. The objective of increasing prepaid care comes from a recognition that about ten percent of their patients default on their health care debt to the hospital. The expectation was (and this is a common issue and expectation for hospitals working with health care financing programmes) that this default level would decrease if significant numbers of patients belonged to the prepaid scheme. Management reports no significant change in defaults that can be attributed to the KPPS.

[7] An organisation of community based health care providers originally funded and overseen by the ILO SEED programme, with additional funding from USAID through DISH and PSI CMS.

Relative to the rest of the hospital activity, the KPPS program is still a rather small though increasing contributor to volumes. For the five quarters ended in March 2002, out-patient KPPS clients represented as much as eleven percent of total out-patient activity, and two percent of total in-patient activity. The growth in KPPS client utilisation relative to total use is represented in the table below. As the chart shows, utilisation is increasing and as it does it is expected that such volumes will bring the product's benefits into focus much more clearly for hospital management.



The hospital management itself has hindered growth of the programme relative to the perceived level of service that patients receive. For much of the time KPPS has been in operation, clients coming to the outpatient department had to suffer with long queues and extended waiting times for patients as a result of inadequate capacity within the Outpatient Department. According to the KPPS manager, as a result of a formal letter that he wrote to management based on his own research of the wait times and service, the hospital hired an extra doctor to speed up access to treatment for patients. Waiting time has since reduced, though it often takes significant time to change the perception of former patients.

This is an important tangible indicator of willingness of management to improve conditions at the hospital. They still have excess space available in their outpatient department and note that they could recruit additional doctors if there was a significant growth in the number of insured members. In addition, the in-patient department experiences an average of about 60% utilisation (though the paediatric and women's units are frequently full). Hospital management are confident that they have the capacity to dramatically increase the numbers served by the KPPS. At least some of this confidence arises from management's belief that most of the new members in the Scheme will likely be current cash basis patients anyway, and that in effect, the scheme is simply shifting cash basis patients to pre-paid basis patients (a much preferable position).

While the hospital's accounts department is over stretched, it is not wholly because of the volume of transactions it has to carry out on behalf of KPPS. This results in the accountant working as a bookkeeper, and remaining unable to conduct management accounting activities

for the hospital or KPPS. This forces KPPS to maintain separate records and inefficiently track KPPS activity. The hospital is in need of additional accounting staff to perform basic accounting duties and to free up its accountant to carry out a more thorough management accounting function.

In addition to the hospital, the scheme has worked with microfinance institutions. However, these relationships were never formalised or clearly defined, and the institutions have shown very little commitment to this product. In a discussion with FINCA (one of the MFIs that continues to work with KPPS), they indicated that their commitment was only to giving the health scheme staff access to client meetings. Both KPPS and FINCA Branch management have deemed that simply providing access with no assistance from the MFI is unlikely to be successful.

Because there was no formal agreement, or understanding of what should be done within this relationship, credit officers (FINCA's front line staff) had a variable response to the program. KPPS's relationship with FINCA started with initial meetings between the scheme's staff and FINCA staff to educate and sensitise them about insurance and to build an understanding of the product. KPPS' expectation was that the credit officers would help market the product. On the other hand, FINCA's expectation was that KPPS would take the lead in marketing leaving minimal responsibility to the credit officer. Some actually involved themselves in marketing the product based on what was learned from the KPPS marketing efforts and a brief training program conducted for FINCA staff by KPPS management. Internally, the FINCA branch manager decided to assist in the collection and safekeeping of client premiums.

FINCA had anticipated an increase in portfolio quality as a result of insured households having in place more effective risk mitigation measures. To date, there has not been any noticeable improvement in portfolio quality as a result of member enrolment in the scheme, though this has not been formally monitored by FINCA.

A serious deficiency in the relationship relates to how the relationship is managed by KPPS. The FINCA Branch manager noted with frustration that communication and follow-up from KPPS was lacking. When it was time for renewal of the policies, KPPS did not even return to promote renewal. She noted that her credit officers had significant feedback on the perceptions of the Scheme by FINCA clients, but after the initial meeting, KPPS management did not return to FINCA. The manager noted that FINCA had "lost touch with" the KPPS manager.

In agreeing to work with KPPS initially, there was no significant due diligence carried out by the MFI to assess its risk in the relationship. The manager noted the reputational risk to FINCA if the quality of service were poor. However, no formal assessment was made and no formal tracking was done to gauge over time the risk to the partner.

This programme represents only a small portion of business for this MFI Branch. At the time of the visit, this branch staff managed one hundred and sixty five village banking groups. Of these groups, only twenty, or twelve percent, where in the catchment area for KPPS. Of those twenty, only a few have participated in the KPPS programme. This limited volume means limited value to the branch manager, and does not warrant significant time. Thus, the management of the relationship cannot be left to the MFI partner and must be undertaken by the Scheme manager.

There is strong need to formalise this relationship in order to clearly define the roles of the different parties. This will allow for better structure of the relationship, and an improved responsiveness on the part of both parties.

KPPS also works with schools and groups of employed people. Here, the scheme has succeeded in securing management buy-in and systems have been put in place by the partner institutions to ease payment of premiums for the insured. In exchange for this, these partner institutions expect good quality healthcare for the insured within their institutions. A significant difference between these and the MFIs is that employers and schools require an efficient and effective means of providing their employees and students with health care services. For MFIs, this is (potentially) desirable, but not necessary.

MEMBER LEVELS OF SATISFACTION WITH THE PRODUCT

In spite of high dropouts from MFI groups, a generally high level of satisfaction from members was reported during focus group discussions. Clients noted that they appreciate the opportunity to access comprehensive healthcare from a reputable service provider.

There have been low re-subscription rates from MFI clients but high retention rates from institutions. This is mainly because the institutionalised groups have in place effective mechanisms of premium collection; these include payroll deductions for employees and premiums that are paid alongside school fees for school children.

The re-subscription rates for MFI clients are about 25% per cycle. This is attributed to:

- Inadequate understanding of the concept of risk pooling – people don't understand why they should re-subscribe only to lose this investment if they do not fall sick. This problem would at least be partially addressed through an increase in the term of coverage, thus increasing the likelihood of experiencing a covered event. The current four-month term is too short for most covered clients to generate utilisation experience (though it is seen as a great deal for the adversely selected who can pay little and get their ills addressed). The experience of the programme thus far is that clients utilise outpatient services on a per person average of once every eight months, and in-patient services once in eight years. Thus is a strong likelihood that a member will not fall ill during the short loan period. Clearly, larger families will have a better "chance" of experiencing a covered event.
- Difficulty in gathering the funds to pay the premiums for MFI clients – the MFI made very limited efforts to assist the client in accumulating premium funds either through savings or through loans.
- The distance to Kitovu hospital – it costs Ushs 2,000 (US$1.10) for a round trip from the centre of Masaka town.
- Perceived quality of health care service by the hospital – because wait times and queues have historically been so long, people do not want to use that facility. The problem is said to have been corrected, but the perception lingers within the market.
- Division of roles within the household – health expenses are considered the husband's responsibility and some of the women who were insured with KPPS said they only continued to do so as a backup in case they fell very sick at a time when the husband was unable to provide for his families needs

In spite of the low MFI re-subscription rates, scheme members spoke very highly of the quality of service they had received from Kitovu, once they got in to see the physician. Some scheme members who participated in the focus group discussions had initially joined KPPS to take care of pent-up demand but renewed their membership because of the quality of care they had received. There was a general agreement however that if KPPS worked with selected clinics within the catchment area this would increase the number of fresh enrolments and renewals.

RISK MANAGEMENT

Strategies for managing risks are detailed in Appendix 1: Managing Insurance Risks: Strategies used by Kitovu Patients' Pre-Payment Scheme

The scheme has in place a policy that clearly defines minimum membership among pre-existing groups (at least 60% of a group must join). However, this policy has been overlooked on several occasions in the interest of expansion. The scheme has suffered from adverse selection as a result. The scheme has especially suffered large losses with microfinance members and has, as a result, changed its focus to lower risk (though likely less poor) groups.

Each family within the scheme holds a membership card with the beneficiaries' photos as a control against fraud.

The scheme has recently been responsible for covering its own losses that had in the past been underwritten by a grant from DfID. The scheme's available funds are rapidly declining. The scheme manager has revised the premiums from Ushs 500 (US$ 0.28) per head per month to Ushs 800 (US$ 0.44) per person per month and instituted a minimum premium of Ushs 12,800 (US$ 7.11) per household per four months in an attempt to improve cost recovery. The impact of not having a donor to back up the program is forcing them to price their premiums more accurately, and to look at how they might better control their expenses. In many ways, this is a positive outcome of the loss of donor funding.

Risks to Partners:

The scheme's Microfinance partners acknowledge that there is a reputational risk for them in having their borrowers enrol within the scheme. Credit officers introduce health scheme staff to the groups and members assume that the health scheme is credible because it is operating within the member groups with the approval of the credit institution. Problems with the health scheme could therefore affect clients' relationship with the credit program.

As earlier mentioned, the scheme is part of the Kitovu Hospital complex. The hospital would be responsible for absorbing losses incurred by the scheme in the event that the scheme's reserves run out.

SWOT ANALYSIS

A detailed SWOT analysis is provided in Appendix 2: SWOT Analysis.

LESSONS LEARNED

Product:

- With MFIs, it is important to require a large percentage (>60%) of group clients in order to minimise the potential for adverse selection. When that rule was broken by KPPS in order to acquire additional members, they suffered from the problems of adverse selection.
- Without a quality service provider, selling insurance can be very difficult. For a time KPPS members were clamouring loudly about the delays in getting treatment at the hospital. This restricted growth in the program because people saw the quality as poor.
- The convenience of access to the service provider is important. Members complained that just getting to and from the hospital for outpatient care was Ushs 2,000 (US$ 1.10). Then they have to pay the Ushs 500 (US$ 0.28) co-payment and wait for a long time to be served. OPD care at a local clinic was said to be only Ushs 2,000 (US$ 1.11). Convenience is important in the decision to use a certain health care facility.

Operations:

- Follow-up with clients of insurance products is critical for renewals. With KPPS there was limited follow-up by the coordinator and many members just dropped out rather than taking the initiative themselves top find out how to renew their policies.

Marketing:

- The bulk of insurance marketing needs to focus on generating an understanding of insurance and risk pooling. Most clients visited did not understand the concepts of insurance and risk pooling. Marketing has to be able to answer the question: "what if I never make a claim?" It is a clear understanding of these concepts that should improve the likelihood of continued usage, and thus renewals.
- It is much easier to market to employers of low-income employees than it is to market to MFI clients. Employers have ready cash or can withhold premiums from wages. The decision can be made for the whole workforce by a single employer or human resources team. With MFIs you need to convince the management, supervisors, field officers, and clients.

Accounts:

- A hospital-based program must manage the accounts of the health care financing programme as a full cost centre, and provide detailed, accurate, and timely information (including financial analysis) to the programme manager. Without this information, the manager is unable to adequately manage the programme, and this increases risk to the hospital.

Partners:

- In partnership arrangements between insurers and other partner institutions like health service providers or MFIs there should be a clear definition of the roles and expectations of each party and the formalisation of the relationship (as in a memorandum of understanding).

Incentives to Preventive Care:

- In a hospital-based programme, there is limited financial incentive for preventive care since the more times they see a patient the more they get paid. However, there does appear to be a moral imperative at work, maybe in particular with regards to mission hospitals, which compels them to provide preventive care. In this case, Kitovu Hospital has an active Community based health care Department which provides health care education and the KPPS scheme itself which has offered subsidised mosquito nets to attempt to address the very high incidence of malaria.

Appendix 1: Managing Insurance Risks: Strategies used by Kitovu Patients' Pre-Payment Scheme

Risk:	General Strategy:	Specific Strategy:
Moral Hazard	Pre-selected providers	The Scheme is owned by the hospital and care is restricted to their facilities.
	Claims limits	Out-patient – patients can only use up to 15,000 per visit
		In patient – patients can only use up to 80,000 per visit
	Co-Payments	Ushs 500 (US$ 0.28) for out-patient care on week days, Ushs 1000 (US$ 0.56) for out-patient care over the weekend, and Ushs 1500 (US$ 0.83) for in-patient care
	Loss review	None
	Exclusions	Optical, dental, ambulance services, open-heart surgery, referrals to other facilities, and private rooms are not covered by the scheme.
	Waiting periods	None
	Proof of event	Insured must present themselves to the KPPS clerk before care
	Member identification	Use of family ID card for identification
	Pre-approval of treatment	Membership is confirmed prior to registration
	Expense verification	Limited - out patient charge sheets returned to accounts
	Deductibles	None
	Initial exams	None
	Use of pre-existing groups	In all cases
	Prerequisites to care	None
	Membership from existing groups only	60% requirement though it has been ignored
Adverse Selection	Whole family membership required	Minimum four members must be covered
	Required membership within groups	60% requirement though it has been ignored
	Defined risk pools	None
	Waiting periods	None
	Tying insurance to other products	No
	Periodic cost evaluation	Carried out when management changed and costs to be reviewed because of low cost recovery

Risk:	General Strategy:	Specific Strategy:
Cost escalation	Preset pricing agreements with providers	Hospital provides list of costs of drugs and treatment procedures each time these are up dated
	Preset drugs list	None
	Co-payments	Ushs 500 (US$ 0.28) for out-patient care on week days, Ushs 1000 (US$ 0.56) for out-patient care over the weekend, and Ushs 1500 (US$ 0.83) for in-patient care
Fraud and Abuse	Computerised ID systems	Computerised Systems in place to ensure verification that patient cover is current
	Coverage limits	Ushs 80,000 (US$ 44.44) per in-patient visit and Ushs 15,000 (US$ 8.33) per out-patient visit
	Physical identification	ID card

Appendix 2: SWOT Analysis

Kitovu Patient's Prepayment Scheme: Institutional SWOT Analysis			
STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS**
PRODUCT			
Comprehensive coverage with an affordable premium	Limited choice of service providers	High costs of health care relative to pre-payment scheme price.	Place of delivery inconvenient to most clients
Reputable provider offering good quality healthcare	Product not priced for institutional viability	One MFI partner offers loans for health care financing premiums in its main office	Pricing not viable
OPERATIONS			
Lean but efficient operations	Inadequate capacity	Utilisation of hospital staff thus no need to post scheme staff in hospital	Inadequate hospital management interest or buy-in
Low administrative costs	No direct reserves though the hospital has agreed to cover any deficits	Available office space within hospital	Initial operational support has been concluded with no new sources available at the time of the visit
	Difficulties in securing renewals of MFI clients resulted in waiving key policies, leading to adverse selection problems		The hospital itself is experiencing significant difficulties related to a transfer of "ownership"
MARKETING			
Good emphasis on educating communties about risk pooling	High drop out rates	Large market	Inadequate support from MFIs for MFI clients
Effective use of examples of clients having benefited from the coverage	Limited growth	Willingness of opinion leaders within communities to market product	
		Best support is from school teachers	
ACCOUNTING			
Basic management accounting was current	Scheme lacks its own financials (scheme activity is included with the hospital accounts with limited departmental accounting)	Assistance avialable from hospital accountant	Scheme is not considered by hospital in their planning and budgeting process
Accounting system produces some key ratios on regular basis	Poorly priced product due to inadequate pricing process		Scheme manager is not part of the hospital management team
Available key ratios were considered in management decision-making	Limited ability to use reports in decision making because of limited output		Scheme manager has no control over premium fund. All is controlled by the hospital.
	Manager reconciles the premiums account with the hospotal only once per quarter.		
RISK MANAGEMENT			
Good controls against fraud	Limited controls against adverse selection are abused by clients	Hospital bears risk in event that funds are fully depleted	Lack of active interest by MFIs is leading to reduction in adherance to controls
Co-payments and treatment limits			

Appendix 3: Patient Flow at Hospital: