

Commercial Market Strategies in Sub-Saharan Africa

Lessons Learned in Community Health Financing

Frank Feeley
October 2003



*Commercial Market Strategies in Sub-Saharan Africa:
Lessons Learned in Community Health Financing*

Frank Feeley



COMMERCIAL MARKET STRATEGIES

Commercial Market Strategies (CMS) is the flagship private-sector project of USAID's Office of Population and Reproductive Health. The CMS project, in partnership with the private sector, works to improve health by increasing the use of quality family planning and other health products and services.

**Deloitte
Touche
Tohatsu**

In partnership with:
Abt Associates, Inc.
Population Services International

OCCASIONAL PAPER SERIES

CMS's Occasional Paper Series addresses important issues relating to the private sector's role in reproductive health and family planning. Papers in the series may discuss lessons learned and best practices, highlighting CMS technical areas and country program operations.

THIS PUBLICATION FINANCED BY USAID



This publication was made possible through support provided by the Bureau of Global Health, Office of Population and Reproductive Health, United States Agency for International

Development (USAID) under the terms of Contract No. HRN-C-00-98-00039-00. The views and opinions of the author expressed herein do not necessarily state or reflect those of USAID or the US Government.

ADDITIONAL COPIES

Commercial Market Strategies Project
1001 G Street NW, Suite 400W
Washington, DC 20001-4545

Tel: (202) 220-2150
Fax: (202) 220-2189
E-mail: info@cmsproject.com

DOWNLOAD

Download copies of CMS publications at:
www.cmsproject.com.

ABOUT THE AUTHOR

Frank Feeley is Clinical Associate Professor of Public Health at Boston University and served as Health Financing Advisor for the CMS project. His training in the law and experience in US health insurance and public health agencies has led to assignments throughout Africa, the former Soviet Union, and south Asia.

ACKNOWLEDGMENTS

With thanks for guidance and information to Peter Cowley, Joy Batusa, Rudolph Chandler, Patricia Mengech, Sister Mariann Tregonning, Phillip Akizingwe, David Dror, and all those who have worked, in offices and in the field, to make the concept of community health insurance a reality.

ABSTRACT

In its efforts to expand the availability of primary and reproductive health care services in the private sector, the Commercial Market Strategies project provided technical assistance to community health insurance plans in Ghana and Uganda.

This paper summarizes the CMS experience and makes suggestions for future technical assistance, including

- raising awareness of the many constraints on including reproductive health benefits in community health insurance
- acknowledging the need for a new financial model that takes into account provider financial conditions to assess the feasibility of community plans
- placing greater emphasis on provider-based plans
- developing methods to increase enrollment and reduce the cost of marketing and premium collection
- maximizing the potential for sale of insecticide-treated bed nets through community plans

KEY WORDS

Community health financing, health insurance, Ghana, Uganda, Commercial Market Strategies, private sector, commercial sector.

RECOMMENDED CITATION

Feeley, F. 2003. *Commercial Market Strategies in Sub-Saharan Africa: Lessons Learned in Community Health Financing*. Washington, DC: USAID/Commercial Market Strategies Project.

COVER PHOTO

Julius, the CMS/Health Partners Marketing Coordinator in Uganda's Gulu district, talks to members of a rock-breaking co-op who have joined the community health plan. Photo by CMS/Frank Feeley.

Commercial Market Strategies in Sub-Saharan Africa: Lessons Learned in Community Health Financing

OCCASIONAL PAPER SERIES
October 2003

CONTENTS

- Executive Summary1
- 1 Introduction5
- 2 Background9
 - Community Health Financing in the Developing World* 11
 - The CMS Experience* 11
- 3 Lessons From the CMS Experience17
 - Benefit Selection — Reproductive Health and Family Planning* 19
 - Plan Sponsorship*21
 - Plan Management*21
 - Pricing and Finance*23
 - Provider Relationships and Contracts*23
 - Marketing and Premium Collection*25
 - Enrollment and Membership Verification*26
 - Adverse Selection*27
 - Pre-Payment and Prevention*28
 - Government User Fees*28

FIGURE

- 1 Willingness to pay for expanded birth delivery benefits among women already enrolled in the Nkoranza Community Health Plan.....13

TABLE

- 1 Uganda cost-recovery data.....14

Executive Summary

EXECUTIVE SUMMARY

In the African countries of Ghana, Senegal, and Uganda, the Commercial Market Strategies (CMS) project provided technical assistance either to develop or support community-based health financing schemes. In these insurance-type schemes, households pay modest premiums on a regular basis (quarterly or annually) and in return receive a defined set of health care benefits from a local provider without having to pay normal user fees at the time of service. CMS has supported these schemes as part of its effort to find innovative methods of health financing that expand the availability of both primary care and reproductive health services in the private sector. While the CMS experience reported here is generally consistent with that already reported in the literature, it does provide a number of lessons that may illuminate further work with community health financing schemes.

REPRODUCTIVE HEALTH BENEFITS ARE DIFFICULT TO ADD TO COMMUNITY-BASED HEALTH FINANCING SCHEMES: For example, because the costs of prenatal care and family planning services are fairly predictable, they may be of lower priority compared to the insured's desire for protection against the cost of an unexpected serious illness. In addition, a financially independent health plan (i.e., one not linked to a health care provider) is totally dependent on premium income and must practice fiscal conservatism. Such caution may lead decision makers to reject sound analysis indicating that a modest premium increase will cover a new reproductive health benefit. Fear of eroding the membership base is difficult to overcome, even with a market study documenting high willingness to pay the required additional premium. Other factors inhibiting the addition of reproductive health benefits include the lack of organized political support and male domination of plan decision-making.

COMMUNITY HEALTH FINANCING PLANS CAN CONTRIBUTE TO DISEASE PREVENTION: An example is the successful *In-Net* experiment by CMS/Uganda, which marketed insecticide-treated bed nets through participating community financing plans. The plans were willing to partially subsidize the cost of the nets once they recognized the prevalence of malaria in the insured population and its negative effect on plan profitability. The *In-Net* program should be replicated in other areas with a high prevalence of malaria.

BIG PLANS ARE BETTER — SMALL PLANS ARE DIFFICULT TO SUSTAIN: This is true for several reasons, even before considering the proportionately higher costs of foreign technical assistance for small projects. First, plans with larger membership have greater protection from random fluctuation in losses. While this risk could be mitigated by reinsurance, such a mechanism is not yet available. (When it does become available, it should be based on a careful definition of losses.) Second, costs are high in educating populations unfamiliar with health insurance, then marketing a specific plan, collecting premiums regularly, and updating enrollment data. Although premium collection costs can be reduced if collected annually, this is difficult for all but the cheapest and most restricted benefit plans, or in regions where the premium can be collected at the time of a single harvest (when most income is received). Another way to lower the costs of enrollment and collection is to add them to existing financial arrangements, such as school tuition or crop sales — some of the most successful CMS-sponsored plans have been marketed to schools. Particularly in Uganda, long-term program success is dependent on enrolling larger groups with attributes that simplify premium collection.

A NEW MODEL IS NEEDED TO ASSESS FINANCIAL SUSTAINABILITY: The usual method of evaluating the financial sustainability of a community health plan — comparing premiums with the user fees that would have been paid for the insured services — is misleading. A full analysis must take into consideration several provider factors, including the relationship of fixed and variable costs, government and donor subsidies, bad debts, and spare capacity. A new financial model is therefore needed in order to set premiums and assess the sustainability of a particular plan. If the plan is to be a risk-bearing organization separate from the provider, it must be properly capitalized or reinsured, and it must negotiate a risk-sharing arrangement with the provider.

BASE NEW PLANS ON EXISTING PROVIDERS: If community health financing is to grow, it will often be necessary to base additional plans on existing providers. This sounds contrary to the community's interest, but there are several reasons why more effort should be devoted to building provider-based plans:

- the provider — private, non-governmental organization (NGO) or government — already has a financial infrastructure and greater ability to absorb risk than a newly formed community plan
- the provider has incentives to improve access to its services through community insurance — expanding its market (thus lowering average costs), reducing bad debt, and making the case to the government for increased budgets or subsidies as a consequence of increased service volume
- hospitals can internalize some of the administrative costs that must be borne in full by the premiums of a freestanding plan.

This is not to say that the community should be denied a role in establishing health financing plans. Where multiple providers exist, community members can be offered a choice of provider-based plans. And where there is no natural competition, technical assistance can be provided to educate community groups and support them in negotiating an insurance contract that reflects their interests.

THE EFFECT OF ABOLISHING GOVERNMENT USER FEES IS INCONCLUSIVE: Finally, abolishing user fees at government facilities does not in itself destroy community health financing schemes. It is true that when government services are free, community members may be less willing to make health insurance payments. But in much of Africa, government facilities can rarely match the quality of service and availability of drugs in private or NGO facilities that do charge user fees.

For these reasons, the Uganda plans sponsored by CMS generally maintained membership through a period when the government abolished user fees at public facilities. It is true, however, that when government rhetoric emphasizes free care, as was the case in Uganda, it can be difficult to obtain the strong local support necessary for effective marketing and high enrollment rates. While Uganda has been unable to fully fund free government health services, its rhetorical commitment to free care has nevertheless prevented political leaders from strongly supporting community health financing initiatives. In contrast, the current national health insurance initiative in Ghana has been more realistic in accepting the inevitability of user fees (both for its own services and for private-sector providers) and encourages the use of community financing schemes to pool the risk for these fees.

1 Introduction

INTRODUCTION

The Commercial Market Strategies (CMS) project attempted to use community health financing plans as a tool to expand the availability and improve the quality of private-sector primary care and reproductive health services: When risks are pooled by community insurance schemes, the utilization of covered services by those enrolled should increase. While CMS originally sought to test this assumption for family planning and reproductive health services, the project found that it could not examine these services in isolation — the incorporation of reproductive health benefits was rarely a priority for plan sponsors or purchasers. As a result, CMS provided a broader range of assistance to plans in Uganda and Ghana, and to a nascent plan in Senegal.

This experience has therefore led to several conclusions about the incorporation of family planning and reproductive health benefits in community health schemes and to wider findings about the structure and management of such schemes. We hope that the findings and suggestions offered here will provide guidance to those who provide technical assistance to community health schemes in the future.

2 Background

BACKGROUND

COMMUNITY HEALTH FINANCING IN THE DEVELOPING WORLD

As experience accumulates with community health financing schemes in developing countries, evidence builds that these schemes can improve access and reduce the economic burden of illness. What is more uncertain is the sustainability of such schemes in the absence of donor support, particularly for technical assistance and marketing.

Much of the available literature was synthesized for the World Health Organization (WHO) in 1997¹ and for WHO's Commission on Macroeconomics and Health (Sachs Commission) in 2001.² As these synthesis reports indicate, much of the literature is devoted to discussing the design of individual schemes and how different approaches affect scheme sustainability.

All of the CMS experience with community health financing is based in Africa and has been informed by work dating back to the creation of the Bwamanda scheme in Zaire in the early 1980s. In Ghana, CMS worked with a well-established plan (Nkoranza) originally based on a Mission hospital. CMS provided analytic assistance in considering a new benefit (normal obstetric delivery). In Uganda, CMS and its collaborator, Health Partners, worked to establish or strengthen small plans originally based on agricultural cooperatives. Neither of these efforts was national. Instead, they were attempts to work outside the government, along with specific providers and community groups, to achieve the goals of improved health care access and social protection. While our ability to evaluate the impact of CMS efforts has been limited, our experience is generally consistent with the literature and the synthesis performed for WHO's Commission on Macroeconomics and Health.

THE CMS EXPERIENCE

CMS is a five-year global project funded by the United States Agency for International Development (USAID) to expand the availability and quality of private-sector reproductive health services. CMS combines social marketing projects (largely for family planning) with efforts to stimulate the offering of private-sector reproductive health services. The CMS project was designed to integrate a variety of tools to expand private-sector delivery of services, and therefore includes a health financing component.

CMS has sought opportunities to develop innovative health financing schemes that expand the availability of private-sector primary care, including reproductive health services. CMS has thus explored how health insurance or risk-pooling schemes might expand reproductive health benefits, including family planning services. CMS global research, reported elsewhere, has used *Demographic and Health Survey* data to investigate the link between health insurance and the use of family planning methods. In addition, a CMS project in Nicaragua worked with the national social insurance program — which has strong reproductive health and family planning benefits — to expand the capacity of capitated private-sector providers to deliver these benefits.

In Senegal, Ghana, and Uganda, CMS worked directly with community health insurance schemes. In these countries, private-sector health insurance is limited to a few employees in the formal sector, and social insurance schemes either do not yet exist (Ghana and Uganda) or are limited to public-sector workers (Senegal). In all three countries public funding of government health facilities is inadequate to meet demand, and out-of-pocket health expenditures are substantial. Community health financing plans are the only risk-pooling mechanisms available to the majority of the population. Despite a few successes, however, such plans cover only a limited number of people. The existing plans, nevertheless, provided the opportunity to bring together the groups that CMS is charged to assist — the private sector and the working poor.

1 Bennet, S; A Creese, and R Monasch. 1997. "Health Insurance Schemes for People Outside Formal Sector Employment." *Current Concerns. ARA Series Paper No. 16*. Geneva: World Health Organization.

2 Jakab, M and C Krishnan. January 2002. "Community Involvement in Health Care Financing: A Survey of the Literature on the Impact, Strengths, and Weaknesses." Presentation on behalf of the World Health Organization/Commission on Macroeconomics and Health at the World Bank; Washington, DC.

SENEGAL

In Senegal, the major labor union representing market vendors, UNACOIS, was considering development of a *mutuelle* (a mutual health insurance scheme) for its 90,000 members. But because the union was uncertain whether a product with reasonable benefits would be affordable or marketable to its members, UNACOIS asked CMS to fund a feasibility study. The effort included an estimate of the cost of alternative benefit packages, as well as a willingness-to-pay study testing the marketability of policies with different benefits and premiums (determined by existing patterns of utilization and unit cost). CMS interviewed 400 UNACOIS members in Dakar and Kaolack to carry out the study. While 95 percent of the members said they were interested in coverage by a *mutuelle*, the market survey suggested that only a relatively low-cost, lower-benefit option would attract a reasonable market share. This response encouraged UNACOIS to proceed with creation of a *mutuelle*, and USAID's *PHRPlus* project assumed responsibility for providing technical assistance for its development. The CMS market research provided insight into the characteristics of UNACOIS members who say they will, and will not, purchase a health insurance plan. The data also identified important factors to consider in designing the benefit package for any community health insurance plan.

GHANA

The Nkoranza community health scheme is one of the oldest and largest in Africa. Based at St. Theresa's Hospital and run by the local Catholic Diocese of Sunyani, the plan was started in 1992 and modeled on earlier experience at Bwamanda in the Congo. Despite Ghanaian government subsidies covering part of its health care delivery costs, St. Theresa's had been forced to charge increasing user fees in order to provide services of reasonable quality. As the fees grew, however, hospital staff saw a decline in hospital occupancy and total revenue. In addition, a growing number of patients presented late in the course of a disease because they had been deterred by the fees. A prepaid community health scheme offered a chance to shore up the hospital's finances while improving health care access for local residents.

By 2000, the Nkoranza scheme had enrolled about 40,000 members, roughly 35 percent of the district's population. (A portion of those not enrolled live near the district border and use a different district hospital.) With its significant market share, the Nkoranza plan managed to become self-supporting after donor support for its initial development ended.³ Church support for St. Theresa's Hospital — the plan's only health provider — suggested an implicit financial guarantee. In 2001, the Nkoranza plan became an independent entity, separate from the hospital. Now a community board sets and collects premiums for the plan, although the hospital remains its sole provider. While plan administrators have their offices at the hospital, their salaries are paid from plan funds.

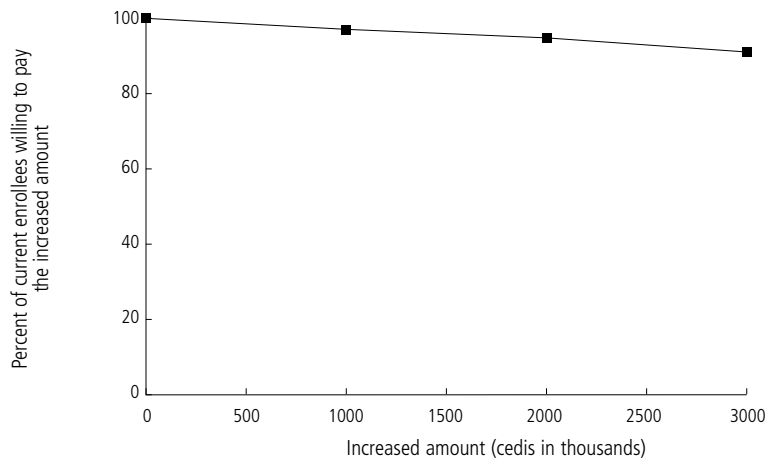
In 2001, at the hospital's invitation, CMS helped the facility assess the impact of expanding the plan's delivery benefit: Caesarian sections (C-sections) are covered in the plan's benefit package, but normal deliveries are not. (A combination of the C-section benefit and a good scheme for referral from community health centers brings 7 to 8 percent of delivering mothers to the hospital for C-sections — a percentage of total district deliveries consistent with the literature on the number of C-sections necessary in rural Africa.⁴) In addition to receiving requests from the community to include normal deliveries in the benefit package, hospital administrators wanted to encourage all high-risk pregnancies to deliver at the hospital. Administrators felt that a properly structured normal delivery benefit could achieve this objective without swamping the hospital with all of the deliveries (about 73 percent of the regional total) that now occur in clinics or at home.

But because the administrators were unsure what such a benefit would cost, how much the annual premium would increase as a result, and what would happen to total plan enrollment with such an increase, they asked CMS for help in performing an analysis. CMS developed a model to estimate total cost and required premium across a variety of scenarios that spanned the possible responses. Variables analyzed

3 From the mid-1990s until an evaluation by Atim et al. in 2000, the ratio of revenue to expenditure (as measured by user fees) was approximately one. Reported in Arhin-Tenkorang, D. 2001. "Health Insurance for the Informal Sector in Africa: Design Features, Risk Protection, and Resource Mobilization"; Working Paper Series, Commission on Macroeconomics and Health, World Health Organization.

4 Dumont, A; L de Bemis; M-H Bouvier-Colle; and G Bréart. 2001. "Caesarean Section Rate for Maternal Indication in Sub-Saharan Africa: A Systematic Review." *Lancet*, Vol. 358, No. 9290, 1328-1333.

Figure 1. Willingness to pay for expanded birth delivery benefits among women already enrolled in the Nkoranza Community Health Plan



included changes in the plan's market share, the proportion of mothers buying health insurance, and the locus of deliveries. CMS also contracted with a market research firm to test the impact of the necessary premium increases on the existing insureds and those not currently buying the policy. This market survey showed widespread support for the additional benefit (see Figure 1) and is reported separately.⁵ Like the UNACOIS study, the survey of willingness to pay higher Nkoranza premiums (support drops only marginally) also provides insight into the demographic characteristics of those who join community health insurance plans and those who do not.

After reviewing with the Nkoranza plan board the factors in determining benefits and setting premiums, CMS presented the results of the study. Risk averse and reluctant to raise premiums beyond the annual increase previously determined, the board elected not to add a normal delivery benefit. The response to the CMS analysis and the debate around this decision provide valuable insight into the decision-making dynamics of an independent community health scheme. The experience also suggests some of the reasons why many community health schemes offer only limited reproductive health benefits.

UGANDA

From 1998 to 2003 the CMS project had broad experience with community health financing schemes in Uganda. CMS/Uganda, working with Health Partners (a US health maintenance organization), provided technical assistance and limited financial support in the development of community health insurance schemes at several locations. Other donors, notably the UK's Department for International Development (DFID), also provided support to Ugandan schemes during this time and have reported their experience elsewhere.⁶ Compared to Nkoranza, the individual schemes are small. According to the Uganda Community-Based Health Financing Association, about 24,000 people nationwide belonged to its member plans in 2002 — less than the enrollment in Nkoranza alone. While each plan uses a designated facility for covered inpatient and outpatient care, the plans are independently marketed to various social and affinity groups. Some of the first plans were based on *engozi*, social groups that pool funds for burials or carry sick members to health facilities. Other plans have been based on agricultural cooperatives. Table 1 shows current premiums and copayments and recent trends in cost recovery (premiums and copayments) versus plan expenses recorded for the Uganda plans.

5 Amoako, N; F Feeley; and W Winfrey. 2003. *Health Financing in Ghana: Willingness to Pay for Normal Delivery Benefits in a Community-Based Health Insurance Plan*. Washington, DC: USAID/Commercial Market Strategies Project.

6 Walford, V; R Basaza; et al. June 2000. "Uganda Community Health Financing Project — Output to Purpose: Review Report to DFID." Institute for Health Sector Development Studies, London. See also Wilson, L. May 2002. "Final Project Evaluation Report: Community Health Financing Project." Department for International Development, London.

Table 1. Uganda cost-recovery data

District	Plan	Provider	Membership	Premiums (Uganda shillings)	Cost recovery, percent (previous quarter)	Cost recovery, percent (most recent quarter)
Bushenyi						
	Kigoma Dairy Cooperative	Ishaka Seventh Day Adventist Hospital	224	10.000=for a family of 4 every three months, 1,500=copay	58	74
	Kashozi Dairy Cooperative	Ishaka Seventh Day Adventist Hospital	127	10.000=for a family of 4 every three months, 1,500=copay	83	57
	Kiyaga Twefeho Microcredit Group	Ishaka Seventh Day Adventist Hospital	63	10.000=for a family of 4 every three months, 1,500=copay	116	115
	Kihyunge Teachers' Group (Karama Tukore)	Ishaka Seventh Day Adventist Hospital	40	10.000=for a family of 4 every three months, 1,500=copay	87	65
	Asasulude Community Group	Ishaka Seventh Day Adventist Hospital	58	10.000=for a family of 4 every three months, 1,500=copay	123	104
	Kanyinya Agroforestry Group	Bushenyi Medical Center	90	12.000=for a family of 4 every three months, 1,000=copay	74	132
	Bumbaire Coffee Society	Bushenyi Medical Center	75	12.000=for a family of 4 every three months, 1,000=copay	79	129
	Bwera Drama Group	Bushenyi Medical Center	75	1.000=per member per month, 1,000=copay	NR	77
	Igara Tea Cooperative	Bushenyi Medical Center/ Buhweju Clinic	456	15.000=for a family of 4 every three months	113	172
	Katinda Drama Group	Bushenyi Medical Center/ Buhweju Clinic	36	15.000=for a family of 4 every three months	NR	75
	Nyakashaka Primary School Staff	Bushenyi Medical Center/ Buhweju Clinic	48	15.000=for a family of 4 every three months	NR	134
	Gongo Twefeho Microcredit Group	Comboni Catholic Hospital	174	1.000=per person per month, 1,000=copay	30	42
	Mashonga Traders	Comboni Catholic Hospital	66	1.000=per person per month, 1,000=copay	34	47
	St. Mary's College Secondary Students	Comboni Catholic Hospital	549	4.000=per student every four months, no copay	70	NA
	St. Mary's College Secondary Teachers/Staff	Comboni Catholic Hospital	41	1.000=per member every month, 1,000=copay	NR	28
	Catechist Group	Comboni Catholic Hospital	82	1.000=per member per month, 1,000=copay	NR	116
Kampala						
	Uganda Microfinance Union	Savannah Sunrise Clinic	90	12,560=per person per month, no copay	NR	103

Table 1. Uganda cost-recovery data (continued)

District	Plan	Provider	Membership	Premiums (Uganda shillings)	Cost recovery, percent (previous quarter)	Cost recovery, percent (most recent quarter)
Gulu*						
	Sacred Heart Secondary School Teachers	Lacor Catholic Hospital	92	Group B, no copay	49	87
	Sacred Heart Secondary School Students	Lacor Catholic Hospital	810	Group A, no copay	NA	91
	Nimaro Women's Group	Lacor Catholic Hospital	88	Group C, no copay	45	72
	Bishop Angelo Negri College Staff	Lacor Catholic Hospital	81	Group B, no copay	57	59
	Gulu Youth Development Association	Lacor Catholic Hospital	20	Group B, no copay	16	37
	St. Joseph Technical College Teachers and Casual Workers	Lacor Catholic Hospital	77	Group B, no copay	64	59
	Gulu Secondary School Teachers	Lacor Catholic Hospital	36	Group B, no copay	NA	139
	Uganda Revenue Authority	Lacor Catholic Hospital	23	Group A, no copay	46	No expenses
	DII Cwinyi Women's Group	Lacor Catholic Hospital	35	Group C, no copay	33	38
	Koch Goma Secondary School Staff	Lacor Catholic Hospital	49	Group B, no copay	137	211
	Norwegian Refugee Council (NRC)	Lacor Catholic Hospital	28	Group A, no copay	105	7
	Konye Ber Construction (KBC)	Lacor Catholic Hospital	38	Group B, no copay	135	102
	Ngeri Primary School Staff	Lacor Catholic Hospital	52	Group C, no copay	NA	86
	St. Joseph Carpentry Workshop	Lacor Catholic Hospital	83	Group C, no copay	NA	53
	Kanyagoga Orphan Care	Lacor Catholic Hospital	36	Group C, no copay	NA	79
	Gulu Prison Primary School Staff	Lacor Catholic Hospital	34	Group C, no copay	95	66
	Catechist Centre Workers	Lacor Catholic Hospital	57	Group C, no copay	NA	53
	Caritas Staff	Lacor Catholic Hospital	101	Group A, no copay	163	100
	Returnees Caritas	Lacor Catholic Hospital	39	Group A, no copay	NA	478
	Bright Valley Primary School Pupils	Lacor Catholic Hospital	48	Group B, no copay	NA	746
	Christ the King Primary Teachers College Students	Lacor Catholic Hospital	43	Group A, no copay	NA	28
	Rwot Bolo Self Help Women's Group	Lacor Catholic Hospital	89	Group B, no copay	63	57
	Mary Immaculate School	Lacor Catholic Hospital	38	Group C, no copay	62	129

NA = not available.

NR = not relevant because scheme started recently.

* Cost-recovery rates from Gulu district include subsidies.

Explanation of most recent quarter: For all plans other than those in Gulu, the most recent quarter refers to the period April–June 2003. For these plans, the previous quarter refers to the period January–March 2003. For Gulu district, quarters for each plan cover a range of time periods, but all fall within the period November 2002–May 2003.

Both private for-profit and religious-based non-profit hospitals provide services to the community health schemes. As in Ghana's Nkoranza plan, many religious and NGO hospitals in Uganda receive a government subsidy, but are still forced to charge user fees in order to deliver service of reasonable quality. (Unlike Nkoranza, however, most of the plans include an outpatient care benefit.) While CMS was working in Uganda, the government discontinued formal user fees for basic services at government-owned facilities, thus providing an alternative for the poorest patients and potentially undermining the market for community health financing. Nonetheless, demand continued strong at many good facilities charging user fees, in part because continued funding shortages left government facilities without adequate drugs or supplies.

The support that CMS offered community health schemes was diverse. (While there was relatively little support in the form of direct subsidies, DFID did provide a form of reinsurance to several plans for a few years.) CMS and Health Partners provided technical assistance, including premium calculations and data-collection systems. CMS also funded community organizers to recruit groups and help market the policy to group members. In addition, these organizers pushed groups to institute such public health measures as building water catchments and digging latrines. The CMS/Health Partners network of plans also was used to sell partially subsidized insecticide-treated bed nets. All plan policies were sold through groups, which were required to enroll 60 percent of their members to protect against adverse selection in enrollment.

In the last two years of their work together, CMS and Health Partners embarked on an innovative insurance scheme in the impoverished war-torn region of Gulu. Using the respected Lacor Mission Hospital as a provider, groups were offered a heavily subsidized benefit package. (Lacor Hospital's user fees were then and continue to be reduced by government subsidies and foreign charitable donations.) CMS provided the hospital with protection against losses if the premium proved insufficient to cover traditional fees for the services used by insureds. In addition, CMS provided a direct subsidy to further lower the cost of the premium to members, with greater subsidies for women and children. Enrolled groups included those with extremely poor members — including a rock breaker's cooperative and a group of refugee widows. Unfortunately,

civil disorder prevented CMS from marketing the plans to extremely poor villages further into the bush.

Through the Gulu premium subsidies, CMS engaged in an experiment often discussed, but little implemented: using subsidized community health insurance as a mechanism for funds to "follow" patients as they seek care, rather than expending fixed budgets on facilities which may, or may not, attract patients. At the same time, CMS's premium-lowering direct subsidies to members made it easier for households to pay to be insured as part of a group, which spreads risk and lowers the cost of care when needed. By paying a fixed premium to the health plan, households avoid having to use scarce household resources to pay large medical bills on their own.

The results of household surveys conducted by CMS suggested that the two main goals of health insurance were being met — access had improved, and fewer families were forced to "sell the cow" (sell assets or borrow money) in order to pay medical bills. After obtaining insurance, a third of insureds sought health care for an illness in the subsequent month, doubling from 15.5 percent before the insurance plan. In the uninsured comparison group, health service utilization also increased, but only by 5 percentage points.

Even more dramatic was the economic effect. Respondents who obtained health care were asked if they had previously been forced to sell an asset or borrow money to pay for such care — 43 percent of enrolled patients and 48 percent of the patients in the uninsured comparison group reported being forced to sell an asset or borrow money. In a follow-up survey, only 16 percent of the insureds who obtained care in the previous month reported borrowing or selling assets, whereas 48 percent in the uninsured comparison group had done so.

The following section explores the lessons from the CMS experience that may improve the design and operation of community health plans in the future. We draw primarily on the Uganda experience, with more limited reference to Nkoranza and UNACOIS and to the experience of USAID's earlier Promoting Financial Investments and Transfers project (PROFIT, 1991–1997).

3 Lessons From the CMS Experience

LESSONS FROM THE CMS EXPERIENCE

BENEFIT SELECTION — REPRODUCTIVE HEALTH AND FAMILY PLANNING

Getting a community health plan to add reproductive health benefits is not easy (see sidebar). Reproductive health is not at the top of the list of desired benefits. In Senegal, 89 percent of UNACOIS members surveyed wanted coverage for outpatient consultations, and 75 percent wanted inpatient coverage. Somewhat fewer — 70 percent — wanted a drug benefit (although the substantial increment in required premium makes the latter a less marketable product). Just over two-thirds of respondents wanted maternity coverage, marginally more than the 64 percent who wanted coverage for laboratory tests.

Adding family planning services is even more difficult. There are a number of reasons. If government facilities provide family planning services for free, few users will see the need to add a benefit they already receive. Even if the benefit is included in a plan, users may not change their patterns of care. For example, when the 1990s PROFIT project sponsored a low-cost, limited-benefit commercial plan (Healthsaver) for the working poor in the Philippines, the service package delivered through capitated local hospitals included family planning. None of the Healthsaver enrollees used the insured provider for family planning.

For those not yet motivated to adopt modern family planning, there is little reason to lobby for coverage of a service they will not use, or may even actively oppose. In Senegal, modern family planning prevalence in the group surveyed was 14 percent in Dakar and 24 percent in Kaolack. Even where family planning users must purchase the service or supplies, these low and predictable costs are not something that most users think to insure. The literature shows that within a reasonable price range, those who are regular family planning users are relatively insensitive to price increases.⁷ The UNACOIS study showed substantial sensitivity to the amount of an insurance premium, so the benefit package had to be limited to those services wanted by the largest portion of the market. Services in less demand were not recommended because they would raise the premium to unmarketable levels. For example,

drugs were not included in the initial recommendation because they would substantially increase the premium and were relatively low on the list of desired services.

Analysis of enrollment data in the CMS-supported plans and elsewhere⁸ shows that those who join community health insurance plans are rarely the poorest of the poor. They are likely to be more educated and perhaps already more likely to use family planning. They are also less likely to find the cost of family planning services a barrier to use. High-cost long-term methods — particularly sterilization — may be the lone exception to the rule that family planning is a secondary factor in designing insurance plans and that insurance coverage is of limited effect in expanding contraceptive prevalence.⁹ Future projects should experiment with the coverage of sterilization benefits through community health plans in societies where there is strong acceptance of this method.

In Uganda, none of the CMS-supported plans chose to offer a family planning benefit. Even though the plans were sold to cooperatives and other community organizations, they often were closely tied with a Mission hospital to provide services. In Gulu, where low-premium plans were sold to some of the poorest groups, it might have been possible to observe whether coverage of family planning services would increase contraceptive prevalence in the extremely poor. But the plan was based at Lacor Hospital, a well-respected Catholic institution unwilling to include a family planning benefit, even if it were provided by an unaffiliated local facility and subsidized directly by CMS, rather than through premiums received by the hospital.

7 Levin, A; B Caldwell; and E-K Barakat. 1999. "Effect of Price and Access on Contraceptive Use." *Social Science and Medicine*, Vol. 49, 1–15. See also Jutting, J. (Center for Development Research, University of Bonn.) January 2002. "Impact of Community-Based Health Insurance on the Access to Health Care: A Case Study From Senegal." Presentation to seminar on community financing at the World Bank; Washington, DC.

8 Criel, B; et al. 1999. "The Bwamanda Hospital Insurance Scheme." Quoting Moens, F. "Design, Implementation, and Evaluation of a Community Financing Scheme for Hospital Care in Developing Countries: A Prepaid Health Plan in the Bwamanda Health Zone, Zaire." *Social Science and Medicine*, Vol. 30, 1319–1327.

9 Winfrey, W; et al. (in progress). "The Impact of Health Insurance on the Use of Family Planning and Maternal Health Services." Washington, DC: USAID/Commercial Market Strategies Project. This study, which is scheduled for publication in early 2004, shows that the use of female sterilization (a service with fairly high initial cost) increased in the Philippines with access to insurance coverage. In general, however, the availability of insurance was not a significant independent factor in contraceptive prevalence in the data sets studied.

Sponsorship, governance, and benefit selection

Nkoranza offers an opportunity to examine the roles of various stakeholders in the selection of benefits. The proposal to expand the plan benefit to include normal deliveries came from the administration of the Catholic hospital where the plan originated. In addition to the traditional pro-natalist sentiment of the Catholic Church, this initiative arose from some community requests and a strong public health commitment on the part of the sister in charge. Hospital administrators recognized that they could not accommodate all district deliveries, but wanted to make it easier for problem pregnancies to access the hospital. The charge/cost ratio for C-sections (already insured) appeared to be higher than that for normal deliveries (not insured). More insured deliveries might have cut an already low rate of patient default while permitting the hospital to increase its price for a normal delivery and recover a larger percentage of the cost.

By the time CMS completed its analysis of the normal delivery benefit, governance of the plan had passed from the hospital to an independent board. While the Diocese and the hospital were represented on the board, they did not control it. No women of reproductive age were present at the board meeting when the study results were discussed. The consultant presented findings that showed a very positive community response to the proposed additional benefit. As shown in Figure 1, just under 10 percent of current enrollees said they would drop the plan because of a higher premium (a 10 to 15 percent increase to the current 15,700 cedi premium) while many uninsured residents said the new benefit would induce them to join the plan.¹⁰ Sister Marianne, the Diocese health administrator, spoke passionately in favor of the new benefit. One young male board member expressed surprise that other males would question the need for this addition, or be unwilling to pay the 10 to 15 percent premium increase required. But there were no other speakers in favor. The opponents were unwilling to revise the 2003 policy year premium and expressed the following reservations:

- The plan had become independent without any capitalization to provide a cushion against inadequate premium income. The premium calculation methodology presented by the CMS consultant suggested that the recently set premium might actually be too low. Without greater financial reserves, the board would take no additional risk.
- The dominant complaint received by community board members was the perceived “high” cost of the premium. Few residents volunteered to the board that they found current premiums reasonable, even if this is what they thought. And no one lobbied the board to cover normal deliveries. Board members feared a loss of plan membership, with reduced coverage of overhead costs and a potential deterioration in the risk pool.
- Male board members complained that the willingness-to-pay study had been conducted among women of reproductive age — those who would use the normal delivery benefit. The males who would be asked to pay the increased premium had not been surveyed. These skeptics discounted the finding that the new benefit might even increase the plan’s market share.

Thus the board refused to add the normal delivery benefit. The decision might have been different if the provider still called the shots. Passing financial responsibility to an independent board with no reinsurance and inadequate capitalization made it more difficult to introduce any benefit innovation. A hospital-based plan might have accepted the risk if only because labor costs — the largest cost element — would not increase as fast as any unexpected increase in demand. The newly independent Nkoranza plan had no such cushion. Finally, women who would benefit from coverage for normal deliveries were not represented on the board, nor did they lobby for the benefit. Even the soundest analysis will not carry the day for a benefit innovation unless constituencies are built, board members are lobbied, and capital is provided to ensure the continued existence of the plan should costs rise more than expected.

¹⁰ Amoako, N; F Feeley; and W Winfrey. op. cit. Tables 2 and 5.

As suggested by an experience of CMS predecessor, PROFIT, it may be easiest to include family planning benefits when the plan sponsor is also a secular provider of primary care. For example, the African Air Rescue (AAR) plan in Nairobi, expanded with support from PROFIT, did include family planning. AAR saw this benefit as a natural extension of the primary care services offered through AAR clinics and was not reluctant to include the costs in the plan.

PLAN SPONSORSHIP

The simplest way to structure a prepaid community health insurance plan is around the dominant provider in a district. This is the way the Nkoranza plan was built: The hospital provides the administrative services — it already has a financial infrastructure. It uses its financial resources to take the risk that expenditures may exceed premium collections. But there can be problems with such an arrangement:

- community suspicion that the plan is being run solely for the advantage of the provider
- lack of provider competition that might drive down prices or improve quality
- lack of community support necessary to enroll citizens skeptical of health insurance and health providers

Even though Nkoranza surmounted these obstacles and obtained strong community and political support, evaluations showed some continuing community distrust, including suspicions that the hospital actually discriminated against insureds because it would collect no additional user fees. In response, the plan put in place a system that prevented treating clinicians from knowing whether a patient had insurance coverage.

The Uganda plans were created with outside technical assistance, but based on existing community organizations. None of these organizations would have had the motivation or sophistication to create and manage a plan without outside help. In some areas, a group was given a choice of facilities, with the technical assistance staff structuring competition between providers. Each group ultimately enrolled with a chosen hospital; the complexity of paying multiple providers was beyond the capacity of the plans.

CMS experience suggests that single-provider plans are the best route for rapid expansion of community financing schemes. An independent plan organizer or large group should negotiate the terms of the arrangement, and the provider should be a partner with the scheme in estimating the premium, sharing risk, and distributing extraordinary risks to reinsurers or to the government (e.g., in the event of an epidemic). In much of the developing world, travel to obtain medical care is a major burden, so the district hospital has a certain natural geographic monopoly and is the logical base for a new plan. Rather than pursuing multiple provider models, technical assistance should focus on

- creating strong community support for the provider-based plan
- creating some counterweight to the hospital in negotiating the terms of a provider agreement
- providing for oversight and complaint resolution independent of the hospital administration, but not necessarily reaching the degree of plan autonomy recently adopted in Nkoranza

PLAN MANAGEMENT

Should a plan have its own independent management? In theory, there are three possible bases for building management capacity — the health care provider, the community organization that sponsors the plan, or an independent technical assistance program.

For the Nkoranza plan, the existing hospital was the source of management services. Nkoranza accepted assistance from CMS to analyze the normal delivery benefit and received an independent evaluation through the PHR*Plus* project, but it had been operating for several years without outside technical assistance or subsidy. The hospital and the Catholic Diocese of Sunyani originally provided the financial infrastructure and staff to maintain enrollment lists and accounts and estimate budgets and premiums — these staff members now work for the plan. The system for collecting annual premiums (community representatives paid a small commission) was developed by the hospital and Diocese, and the control procedures for this efficient collection system were also inherited by the newly independent plan.

In some mutuelles in Francophone Africa, the administrative functions (e.g., premium collection and claim payment) apparently have been handled successfully by the existing officers or leaders of these associations.¹¹ Where social cohesion is tight, this may work. In Uganda, however, there were problems with groups collecting premiums and turning over aggregate collections — there have been instances where the designated collectors pocketed the money without enrolling the member. (Unlike Nkoranza, the collectors receive no payment for the collection effort.) In addition, when premiums are collected quarterly instead of annually, there is more work for a group's leader. CMS's experience suggests that premiums are easiest to collect if a plan can piggyback on another financial system or transaction: for example, by adding the premium to school tuition or union dues, or deducting it from the proceeds of crop sales.

In Uganda, initial plan management and marketing were effectively handled by the CMS/Health Partners staff — the small groups that form the basis of the Uganda plans lacked the necessary skills and could not afford the costs. Most small groups now belonging to Uganda schemes would have dropped out without the early CMS/Health Partners support, unless the responsibility for premium collection had been shifted to the participating hospitals.

In the long run, there are a limited number of ways in which community-based health plans can obtain adequate management at acceptable cost:

- The provider (district or Mission hospital) organizes and manages all aspects of the plan. It can then market to the entire district, or negotiate to enroll individual affinity groups. These groups may negotiate for some changes in the standard premium or benefit, but otherwise leave all matters of enrollment, premium collection, and payment for individual services to the hospital.

- The plan is initiated by a large group (e.g., a big union, such as UNACOIS) that has financial and administrative capacity and can perhaps add premium collection to its existing arrangements, such as dues collection. Initially, even large organizations in developing countries will need foreign technical assistance to develop administrative capacity. In the longer run, the sponsoring organization may think about spinning out the plan so that additional groups can join and obtain the advantages of the plan's management systems and provider contracts.
- A national technical assistance organization is created to help smaller affinity groups negotiate or establish community health financing schemes. The costs of technical assistance would then be determined by local, not international, salary scales. In the short run, this will almost certainly require donor funding. In the longer run, if the volume of membership in community plans is sufficient, such an effort might be sponsored through a reinsurance company established to distribute the risks associated with insuring small groups.¹²
- Local or district-level governments faced with the inevitability of user fees and committed to the idea of equitable risk pooling decide to sponsor a community plan. These government entities must actively market the plan and negotiate the provider arrangements. The provider may be the government health service, as it was in Rwanda. This district-wide approach now appears to be the direction taken by national policy in Ghana. Such plans might be able to contract for administrative services, such as premium collection, enrollment updates, provider payment, and data collection. Given the limited technical resources currently available, donor assistance in developing these third-party administrators (and designing the district plans) is likely necessary. Ultimately, large plan enrollments might cover the cost of administrative services within an affordable premium.

11 Atim, C. 1999. "Social Movements and Health Insurance: A Critical Evaluation of Voluntary, Non-Profit Insurance Schemes With Case Studies From Ghana and Cameroon." *Social Science and Medicine*, Vol. 48, No. 7, 881–896.

12 Feeley, F; D Gasparro; and K Snowden. 2002. "Assessment of Piloting Social Reinsurance in the Philippines," in Dror, D and A Preker (Eds.). *Social Reinsurance: A New Approach to Sustainable Community Health Financing*. Washington, DC: World Bank.

PRICING AND FINANCE

A simple comparison of user fees and premiums does not tell the whole financial story. For example, in Uganda, DFID performed a thorough and competent evaluation of the financial sustainability of the plans it had reinsured. DFID agreed to reimburse losses sustained if the user fees that would have been collected exceeded premiums and copayments actually collected from the insured group. According to this formula, most groups, except for some of the school plans, lost money most of the time.

But this analytic methodology does not tell the whole story. Because government operating subsidies cover only a portion of routine operating costs at most hospitals, user fees must be set above the level necessary to recover variable costs (including drugs, supplies, and food). User fees also make a contribution to the fixed costs of running the hospital. In effect, the provider can deliver additional services at an incremental cost lower than the user fee. It has to, or it would never be able to recover the fixed costs not covered by subsidies. By catering to community insurance plans, a provider can earn revenue that it might never have taken in from user fees; those with high medical needs might never be able to pay those fees and would not use the facility. So long as the variable costs of the services used by insureds do not exceed the premium revenue, the provider comes out ahead. In addition, there is no risk that a properly insured patient will default on a bill, so the provider can reduce its bad debt. In Uganda, when plan membership increased the hospital's service volume, it also provided valuable support in negotiating with the government to increase a Mission hospital's operating subsidy.

Nkoranza shows that a comparison of premiums and user fees forgone does not provide the full financial picture. The new Nkoranza plan board was fiscally more conservative, in part because it was required to pay full user fees. If those user fees exceed variable costs, the hospital will benefit from expanded patient volume. It may do so even if the premium income is less than would have been achieved from user fees. But the newly

independent plan no longer shares in this benefit. In addition, the plan now absorbs even more risk because it is forced to set its annual premium before the hospital sets its user fees for the following year.¹³

These findings lead to two conclusions and recommendations for future technical assistance to community health plans:

- A new financial model is needed, particularly for facility-based plans or those that provide a significant share of facility revenue. This model needs to (1) recognize the difference between user fees and variable or marginal costs and (2) permit calculation of changes in the facility's profitability at different levels of premium, total enrollment, and utilization of services by insureds.
- When community plans become independent of the host facility, as in Nkoranza, they need to negotiate risk-sharing arrangements with the provider, preferably with provision for the hospital to share a portion of any surpluses resulting from the excess of premium revenues over associated marginal costs. In addition, facilities and plans should align their financial planning cycles so that user fee levels will be known before the plan must determine its premium.

PROVIDER RELATIONSHIPS AND CONTRACTS

A key element of the technical assistance provided in Uganda by CMS/Health Partners was the drafting of contracts between the insured groups and the chosen provider. These contracts accommodated some variation in benefits between individual plans, based on group preference, provider costs, and marketable premium levels. As noted above, CMS/Health Partners actively recruited groups to join the health financing schemes. Even in the unlikely event that such groups would have spontaneously sought to create a prepaid arrangement, it seems unlikely that the group would have been able to develop such a contract.

¹³ This occurs because the hospital does not set user fees until it knows the level of subsidy that will be received, and this depends on the government budget. The Nkoranza plan sets premiums in August so that they can be collected during the harvest season in October and November. The hospital does not receive notification of its subsidy until near the end of the year; hospital administrators then calculate the user fees required to break even.

St. Hypothetica Mission Hospital:

The profitability of a plan depends on whose “books” you read

To illustrate the pricing and finance discussion, consider the following example. St. Hypothetica is a Mission hospital with 100 beds. There are 10,000 people in the surrounding community. Before a community health financing scheme is organized, this is the hospital's financial situation:

Total operating budget (in units of local currency)	
Fixed costs (labor, capital), of which 4 million is a government subsidy	10,000,000
Variable costs (drugs, supplies)	4,000,000
Total cost of operations	14,000,000

Activity	
Inpatient days (60.3% occupancy)	22,000
Clinic visits	25,000

Cost per unit of service	
Inpatient day, of which 141 is a variable cost	495
Clinic visit, of which 35 is a variable cost	124

Bad debt/free care	10% of total days/services
---------------------------	----------------------------

User fees	
Inpatient day	400
Clinic visit	100

Net revenue	
Government subsidy	4,000,000
User fees	10,170,000
Total revenue	14,170,000

Operating surplus (deficit)	170,000
------------------------------------	----------------

Now consider what happens if the community develops a prepaid financing plan in which half the population (5,000 people) enroll at an annual premium of 1,200. This results in a 5 percent increase in total utilization for both inpatient and outpatient care, all of it by those who join the plan. There is no increase in fixed costs, and the government subsidy remains the same. The remainder of the services provided to the rest of the community yield the traditional user fees, with a 10 percent bad debt rate. For simplicity, we will assume that the plan has no administrative costs, although this would not be the case. The plan would have to consider these in setting its premium.

In the Ugandan study, plan profitability was determined by comparing the premium to the user fees that would have been collected on the services provided to plan members. In our plan, this is the result of the analysis:

Premium income	
5,000 people x 1,200	6,000,000

User fees	
Inpatient 12,100 days x 400	4,840,000
Clinic visits 13,750 x 100	1,375,000
Total cost	6,215,000

Operating surplus (deficit)	(215,000)
------------------------------------	------------------

The income statement for St. Hypothetica Hospital, however, is shown below. Note that the hospital is taking into income the full amount of premiums collected. If it actually had received the user fees on services used by plan members, rather than the premium, its total revenue would have been about 1.5 percent higher.

St. Hypothetica	
Expense	
Fixed cost	10,000,000
Variable cost	4,200,000
Total cost	14,200,000

Revenue	
Government subsidy	4,000,000
Community plan premium	6,000,000
User fees	
Inpatient	3,960,000
Outpatient	1,125,000
Total revenue	15,085,000

Operating surplus (deficit)	885,000
------------------------------------	----------------

The community plan shows an operating deficit of approximately 3.5 percent of revenue if it pays user fees. However, St. Hypothetica Hospital's operating surplus actually increased from \$170,000 (1.2 percent of revenue) to \$885,000 (5.9 percent of revenue) because of the plan.

Nkoranza, on the other hand, had no provider contract. Until 2001 it did not need one, since the plan and the hospital were effectively one entity. When plan members complained — as they did about perceived second-class patient status — it was up to the hospital administration to craft a response. Now that the Nkoranza plan is organizationally and financially a separate entity, the development of a contract is a priority. First, the agreement must establish a risk-sharing arrangement between the hospital and the plan. The risk formerly absorbed by the hospital has now passed completely to the plan, which is not capitalized to support it. As shown in the earlier example, there are situations in which the hospital could make money while the plan runs at a deficit.

In the Uganda plans, the provider receives the entire premium. Thus, there is no need for a risk-sharing agreement: The hospital is taking all of the risk and gets all of the benefits if the insured population generates incremental income in excess of variable costs. The hospital must determine for itself whether the offered premium is adequate. If the premium is too low, the hospital can refuse to accept the plan, or drop out of it. At Nkoranza, the hospital is now receiving its user fees and has no direct interest in setting the premium, other than its desire to keep the plan afloat. One option is for the plan to turn the premium (less a small administrative allowance) over to the hospital in lieu of paying user fees, but the hospital would then need to participate directly in the premium-setting exercise. If the existing arm's-length relationship between the plan and the hospital continues, the two should negotiate a "corridor" type of risk-sharing arrangement, in which the percentage of user fees paid to the hospital decreases below 100 percent if per-beneficiary utilization estimates are exceeded (a situation in which the plan will now lose money) and increases above 100 percent when utilization falls below expected levels (a situation in which the plan should now make money). Determination of these risk corridors can be facilitated by tracking average per-recipient utilization (not just total cost) and by applying the more sophisticated financial model discussed above.

While the proper financial relationship between the plan and a provider is the most difficult item to establish in a contract, several other issues should be covered:

- procedures for verifying current enrollment status (i.e., how does the provider know that a patient is currently eligible?)
- allowable benefits and benefit exclusions
- payment schedules — the plan should choose between keeping the premium money in the bank until billed by the provider (as Nkoranza does, thus earning interest), or turning over premium income (minus any administrative allowance) and letting the provider take advantage of this financial float, with subsequent payment adjustments
- dispute resolution protocol, especially when an insured believes that he has been denied a covered benefit or given substandard medical care

MARKETING AND PREMIUM COLLECTION

Big is better, and small is difficult to sustain:

That is the marketing lesson from earlier PROFIT experience and more recent CMS experience. In Uganda, most of the plans developed by CMS and Health Partners were initially based on small agricultural cooperatives: Typical groups enrolled from 20 to 200 individuals. Several groups obtained the same benefit package from one hospital. But each group was marketed separately, a substantial task when the market does not understand the product or the benefits of prepayment and risk pooling. Even after the necessary 60 percent sign-up level is achieved, premiums must be collected, usually every quarter. Updating membership records is costly, even when the group assumes the responsibility for premium collection. There is encouraging evidence that the plans neared sustainability if premiums are compared to the fees for health services consumed. But there is no way that premiums of \$1 to \$3 per person per quarter, as charged in Uganda, can cover benefits *and* the costs of photo ID cards and premium collection, let alone marketing to small groups and obtaining technical assistance. PROFIT's experience with the commercial Health-saver plan in the Philippines was the same. Providers managed to break even or better on the capitation they received from the monthly premium. However, the cost of selling individual policies and collecting premiums every month consumed more than the 40

percent of premium remaining after payment of the capitation. High administrative costs per enrollee with small groups (or individuals) only exacerbate the financial risks associated with the fluctuation of costs in small groups.¹⁴

Nkoranza provides a contrast to the Uganda experience. It is marketed to a large group — the entire district — and sold through enrollment agents in each village. Strong political support has enabled the Nkoranza plan to maintain a sufficient market share to avoid serious adverse selection and keep down per-enrollee administrative costs. These costs are further reduced by collecting the premium once per year at harvest time and paying the village agent a small incentive (or commission) for the effort.

In Uganda, CMS and Health Partners have been keenly aware of these cost pressures. The Uganda plan in Bushenyi shows the benefits of selling to large groups that have the capacity to collect premium from the insureds. The Bushenyi plan is sold to many secondary schools in the area. In addition to having relatively low-risk enrollees (teenagers), premiums can be collected by the schools along with tuition, bringing several hundred people into the plan with each sale. There may be some lag in obtaining the premium money from cash-strapped intermediaries like the schools, but this is still preferable to marketing and enrolling organizations that yield only 20 to 200 new insureds with each sale. The for-profit Bushenyi provider has continued to sell the policies on its own after the withdrawal of DFID reinsurance, confirming that the facility's bottom line is positive for these larger groups. In 2003, data reported by the Bushenyi plans showed combined quarterly cost-recovery rates (premiums plus copayments divided by user fees forgone) of 97 percent, 209 percent, 72 percent, and 140 percent, respectively. For this provider, the prepaid school plans clearly led to a profitable expansion of the market.

The Uganda plans have not yet seriously attempted the district-wide marketing used at Nkoranza. In Nkoranza, local leaders accepted the inevitability of user fees and strongly supported the plan and its marketing campaign. Traditional tribal leaders as well as local elected and appointed officials urged

their constituents to join the plan. These leaders are all represented on the new Nkoranza plan board. In Uganda, the government's commitment to free care at government health facilities makes such local support more difficult to obtain. Even though constituents may accept the inevitability of paying user fees to receive adequate quality care, politicians are loath to strongly support community health financing schemes when the government has said it will provide care for free. This restraint on government support for community health financing, not the actual provision of free care at government facilities, is the greater barrier to broader marketing of community financing in Uganda.

As of this writing, CMS and Health Partners continue to search for large groups that will streamline marketing and premium collection. Premiums are now collected from some tea growers by deducting from crop sales to the processing plant (just as the plant recoups its advances for fertilizer and agricultural inputs).

The lessons for marketing can be summarized as follows:

- target groups that are as large and homogeneous as possible
- consider marketing to an entire village or region if political support is strong and an efficient (preferably annual) premium-collection mechanism is available
- look for intermediaries that will collect the health insurance premium as part of a larger financial transaction, such as tuition payment or crop purchase

ENROLLMENT AND MEMBERSHIP VERIFICATION

The Uganda plans issue photo identification cards to prevent fraud. This step was taken when evidence developed of substantial sharing of the card and the insured benefit by individuals who had not paid the premium. The Nkoranza plan has not yet taken this step; it is not too worried about the potential for fraud. The difference in attitude toward photo IDs may be a function of the difference in benefit packages. The Nkoranza benefit is limited to inpatient services, with the exception of dog bites and snakebites (which

14 Bonnevey, S; D Dror; G Duru; and M Lamure. 2002. "A Model of Microinsurance and Reinsurance," in Dror, D and A Preker (Eds.). *Social Reinsurance; A New Approach to Sustainable Community Health Financing*. Washington, DC: World Bank.

are covered to encourage early treatment). In Uganda, however, the plans cover outpatient care and prescription drugs. Nkoranza has resisted offering an outpatient benefit because the required premium increase would be high, even with modest utilization. With an admission rate of less than 10 percent of insureds each year, the Nkoranza provider (St. Theresa's Hospital) has far fewer encounters with insureds to monitor. While it certainly would be possible for an uninsured patient to borrow a non-photo identification card and seek care, such a charade is more difficult to carry out if the patient is hospitalized, perhaps for several days. Inpatient-only plans, such as that at Nkoranza, may discourage patients from seeking care early in the course of a disease, but they can have lower premiums (perhaps collectable annually), lower administrative costs, and a lower risk of fraud.

ADVERSE SELECTION

Adverse selection is a problem in any health insurance system in which coverage is not universal. In more-sophisticated schemes, adverse selection may be controlled by some combination of selective underwriting (refusing to cover high-risk individuals), waiting periods, and exclusion of pre-existing conditions. All of these techniques violate the social objective of equitable risk pooling between healthy and sick, but may be necessary for the survival of the insurance plan. South Africa has recently revised its regulatory regime to deal with increasingly sophisticated schemes by the insurance industry to sort high-income, low-risk customers into separate plans.

How does a community-financing scheme protect itself from adverse selection while remaining true to the principle of equitable risk pooling? In Uganda, the plans have used two methods. No member of a new group was covered until 60 percent of the group enrolled. This prevents a few individuals with pent-up medical demand from joining the scheme while the rest wait until they have a medical need before paying the premium. Even so, low-cost recovery rates for the early months of coverage in most groups suggest that some enrollees signed up because they had an immediate medical need. The 60 percent rule was cited by both members and marketing staff as one of the barriers to expanding plan enrollment, but reported cost-recovery ratios likely would have been worse if it had not been enforced.

The second technique used in Uganda was to exclude the coverage of chronic illnesses, particularly the drugs required for treatment of hypertension and diabetes, from the benefit package. This, rather than a specific maximum enrollment age, reduced costs due to the chronic illnesses of aging. HIV/AIDS is excluded in the Uganda plans (and there is no antiretroviral benefit), but the plans undoubtedly pay a substantial amount for treatment of opportunistic infections. Based on the reports available, malaria appears to impose the most costly disease burden, with cost-recovery ratios falling during malaria season. If drugs for chronic disease had been included in the benefit package, the premiums would have been higher, and it might have been even more difficult to reach the 60 percent enrollment trigger in many groups.

Nkoranza does not impose a 60 percent rule. The only limitations on enrollment are a maximum age and the requirement that all members of a family be enrolled.¹⁵ But the Nkoranza plan has achieved a relatively high market share. The recorded share of enrolled district population (varying annually between 25 and 37 percent) probably translates to a share in the relevant market of more than 40 percent, since some villages in the district are within the natural service area of another (Mission) hospital. Of those living in the town of Nkoranza, 45 percent belonged to the plan, as did 38 percent of those living in a village at a distance of 14 kilometers from the hospital. In a town 26 kilometers away, enrollment was less than 10 percent.¹⁶ This correlation of enrollment percentage and proximity to the plan provider was reported for the Bwamanda plan as well.¹⁷

The large size of the Nkoranza plan enables it to reduce the risk of adverse selection, lower per-insured marketing and premium collection costs, and increase the ability to absorb random fluctuations in risk. The analysis by D. Arhin-Tenkorang faults the Nkoranza plan for setting its premium too high, reducing both the percentage of the population covered and the total amount of revenue generated.¹⁸ Nkoranza premium revenue has been sufficient to cover costs, so the impact of any adverse selection

15 This prevents the family from selectively enrolling only those members with known medical needs.

16 Arhin-Tenkorang, D. *op. cit.* 36.

17 Shepard, D and E Kleinau. August 1990. "Health Insurance in Zaire." PER Working Paper No. 489, Africa Technical Department, World Bank; Washington, DC.

18 *Ibid.*, 43.

with the existing enrollment percentages is not fatal. Plan enrollees do show higher-than-average service utilization, and lower premiums and expanded enrollment likely will not reduce per-insured utilization to the average currently observed in the uninsured. Variable costs from increased total utilization by the larger pool of insureds could rise to the point that the plan will run at a deficit with lower premium rates. With the percentage enrollment presently obtained at Nkoranza (over 40 percent in the geographically proximate population), the risk of adverse selection seems to be controlled, while the premium charged does cover increased utilization in the enrolled population.

The lesson from Nkoranza and Uganda is that the 60 percent rule might be waived in a situation where there is strong political support for a campaign to market an affordable plan to the entire population of a service district. Technical assistance should focus on ways to enroll large populations; balancing willingness-to-pay studies; and expected utilization and analysis of the provider's financial situation to set premiums that will capture 20 percent or more of the entire target audience. Because plan sustainability must be considered, policymakers should look at subsidizing the premium for the poorest to expand enrollment further, rather than setting the basic premium so low that the plan is not self-sustaining.

PRE-PAYMENT AND PREVENTION

A mantra of those who support capitated pre-payment of health providers in developed countries is that such a payment system gives the provider a real incentive to *maintain* the health of the insured and *prevent* disease. In developing countries, private providers have concentrated on curative care, with the government taking responsibility for prevention. The exception is in the area of maternal and child health, where Mission hospitals have been proactive in promoting prenatal care and, sometimes, immunizations. Other private providers have shown little interest in wider prevention efforts. People who join community health financing schemes are not generally seeking preventive services; they want protection from the high costs of care when they become sick. Nevertheless, the CMS/Uganda experience suggests that community health financing schemes can enhance disease prevention. The CMS experience also shows that synergies can develop between social marketing and community health financing schemes.

For example, it is becoming increasingly clear to many of the community health schemes in Uganda that malaria is a major source of their costs. At the same time that CMS was working with the community health financing plans, the CMS Project began a social marketing program for insecticide-treated bed nets (*Smart Net*). As part of the *Smart Net* marketing program, CMS offered nets to the plans at a reduced cost if the plans would further subsidize a portion of the cost and sell the nets to their members. The CMS *In-Net* project further supported the plans in selling the nets by providing promotional materials. Typically, a treated net costing CMS 8,000 shillings was resold to the insured at 6,000 or 7,000 shillings. By July 2003 about 5,500 *Smart Nets* had been sold in this way. More than 3,000 nets were sold in the three largest plans enrolling a total of 12,000 members. In these plans, one in four members acquired a bed net through the plan. The Gulu plans did even better; nets were sold to 74 percent of members in just seven months.

A CMS tracking study showed use of nets increasing from 22 percent of households to 38 percent during the year of the *Smart Net* campaign. Sixty percent of the households reported observing the health benefits of the nets. Although statistics are difficult to compare because each malaria season is different, providers report that patients in the plans purchasing bed nets seem to present less frequently for malaria treatment.

GOVERNMENT USER FEES

If services are truly free and of reasonable quality, there is no need for a community insurance plan. However, countries at the level of development seen in Ghana and Uganda do not have public-sector revenue that permits full public funding of primary care and basic hospital services. In addition, most governments find it difficult to cut back financial commitments to tertiary care hospitals. As a result, services are under-funded, and the public system compensates in a variety of ways, from de facto reductions in service hours to informal user fees or leakage of drugs and supplies.

For example, near the Nkoranza hospital in Ghana is a brand new regional inpatient facility, completed at the time the Nkoranza analysis began. A year later, when the CMS analysis was finished, the facility still had not opened because the government did not have sufficient budget to staff and supply it. The current centerpiece of Ghanaian health policy is the continuation of user fees, with community insurance plans like Nkoranza to provide risk pooling for payment of these fees.

The phenomenon of informal payments, service deterioration, and drug leakage in Uganda in the mid-1990s is extensively documented.¹⁹ The CMS-marketed *Protector* condom effort found the condom market in Uganda undercut by products leaked from the public sector. While the literature shows that user fees may cut the demand for some primary care services, it is also clear that de facto user fees (such as the need to purchase out-of-stock drugs) usually continue. In Uganda, the government officially removed user fees at public clinics in advance of the last election. While this may have eased the burden on the extremely poor who could not afford premiums in the Uganda plans (or who did not belong to an organization that would qualify them for membership), there is no evidence of a sharp dip in plan enrollment with the repeal of user fees. The population segment that joined the Uganda plans, the working poor, seemed willing to continue paying premiums and obtaining services at the Mission hospitals that still charge user fees, rather than leaving the plans and seeking free care at government clinics.

A discussion with one of the poorest enrolled groups (the stonebreakers at Gulu) confirms that the public facility provided care-of-last-resort for this group. Access to the higher-quality Lacor Mission Hospital, impossible for many even with Lacor's low user fees, was seen as the major advantage of the community financing plan.

In summary: if the government can provide a sufficient volume of adequate-quality free care, there is no need for community financing. But the overwhelming evidence at the level of development discussed here is that public finances are inadequate to provide the level of service the population demands. User fees — formal, informal, or in the form of commercial drug purchases — are inevitable. Although there are many problems in organizing community health financing schemes, competition from free public care likely will remain a second-order concern for the foreseeable future.

19 McPake, B; D Asimwe; et al. 1999. "Informal Economic Activities of Public Health Workers in Uganda: Implications for Quality and Accessibility of Care." *Social Science and Medicine*, Vol. 49, 849-865.



COMMERCIAL MARKET STRATEGIES
NEW DIRECTIONS IN REPRODUCTIVE HEALTH



FUNDED BY:
US Agency for International Development
USAID Contract No. HRN-C-00-98-00039-00

Commercial Market Strategies
1001 G Street NW, Suite 400W
Washington DC, 20001-4545
Telephone: (202) 220-2150
Fax: (202) 220-2189
Web: www.cmsproject.com

**Deloitte
Touche
Tohmatsu**

IN PARTNERSHIP WITH:
Abt Associates Inc.
Population Services International