"Developing partnerships to insure the world's poor"

Microcare Ltd. Health Plan (Uganda)

Notes from a visit 17 – 21 June 2002

(Research conducted for *MicroSave-Africa*)

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INTRODUCTION AND BACKGROUND

Microcare is a not-for-profit organisation involved in the provision of heath care financing services to selected groups throughout the Kampala/Entebbe (Uganda) area. The organisation was registered in 2000 as a limited company and started actively recruiting clients since July 2001. The initial intention was that Microcare would work exclusively with MicroFinance Institutions (MFIs) to develop its client base. Currently, Microcare has 776 clients, 89% of whom are MFI clients. MFI clients still constitute Microcare's key market though this exclusive focus has proven unviable. Thus, the institution has plans to target other organisations with large volumes of low-income members, customers, or employees within formal and informal sector, as well as health care financing administration for this market. At the moment, Microcare enjoys an almost near monopoly of its target market, while other health care financing companies focus on more affluent clients.

MICROCARE'S PRODUCTS

Microcare's health care financing activities involve offering a single comprehensive health care cover package. The company also provides third party administration services for the health insurance schemes of other companies in addition to being involved in developing information systems for health insurers.[1] Below is a description of Microcare's core microinsurance product (exclusive the TPA and IT development lines of business).

PRODUCT	
Eligibility Criteria	▪ Potential clients must be members of a group (not necessarily MFI group) ▪ From each participating group, at least 50% of the members must join the Health Plan (to avoid adverse selection). ▪ Any participating group must have at least twelve premium paying members
Coverage	▪ Outpatient and In-patient services ▪ Surgery ▪ Tests and investigations (x-ray, ultrasound, electrocardiogram, lab tests) ▪ Pharmacy ▪ Maternit ▪ Dental services (fillings, tooth extraction and general consultation) ▪ Optical consultation
Duration of Cover	▪ Policies are written for eight months or one year
Exclusions	▪ Dental surgery ▪ Optical appliances ▪ Sight correction (other than general optical consultation) ▪ Hearing aids ▪ Cosmetic surgery ▪ Self inflicted injury or injury arising from involvement in riots, civil commotion, political or illegal activities ▪ Nervous and mental disorders ▪ Investigation and treatment of infertility ▪ Alcoholism and drug addiction ▪ Injuries resulting from sports ▪ Medication for chronic ailments ▪ Private room charges and any other private charges for drugs or surgeon
Limitations	▪ Medications limited to agreed drugs, dosages, and prescription durations ▪ Hospitalisation for patients with chronic illnesses limited to 3 weeks of within an 8 month period (or a maximum of Ushs 350,000 – US$195) ▪ Only services and products from hospitals, clinics, and pharmacies listed on the approved Microcare list will be covered. ▪ Care is provided starting one week after full payment of premiums.

[1] Recently AON, the largest insurance broker in the world, has purchased the Microcare IT system, and plans are for Microcare to service AON clients in a similar manner to the servicing of the direct Microcare clients.

Mode of Delivery	▪ Health care delivery by hospital physicians staff ▪ Agreed health care costs are paid directly to the provider by Microcare. ▪ Administration for health care services is conducted by the Microcare Check-in Desk nurse at each hospital.
PRICING	
Premium	▪ Family of four – Ushs120,000 (US$67) per year or Ushs80,000 (US$45) per eight months ▪ Additional adults – Ushs36,450 (US$20) per adult per year orUshs27,000 (US$15) per eight months ▪ Additional children (below 16) – Ushs17,550 (US$10) per child per year or Ushs13,000 (US$7) for eight months
Method of payment	▪ Lump sum at beginning of period (one MFI is offering a loan product to assist with this payment)
Other	▪ Patients pay a registration fee to the hospital, like all other hospital patients, before consultation with the physician. The fee represents the co-payment, and varies by provider. This fee ranges from Ushs1,000 to Ushs3,000 (US$0.56 to 1.68) with after hours consultation costing slightly more. ▪ For families covering more than eight members or wanting to make changes to the ID card within the period of the policy, an additional card must be purchased at Ushs5,000 (US$3).
PLACE	
	▪ Services are available at 4 hospitals in the Kampala area – Nsambya, Rubaga, Kibuli and Kisubi, as well as Metromed clinic. Selection of their provider is entirely left to the clients on an incident-by-incident basis.
PROCESS	
Enrolment/Renewal	▪ Group members pay the premiums, completes enrolment form, and provides passport photos of intended beneficiaries ▪ Clients receive their identification cards one week later ▪ Clients are entitled to services commencing one week after payment of premiums
Receipt of Treatment (See Appendix 3)	▪ A detailed process map covering access to health care under the Microcare methodology is provided as Appendix 3. ▪ A copy of Medical Treatment Access Card (MTAC), tracking activities and fees is returned to check-in desk for onward transmission to the head office, and the patient receives a copy for their records.
PHYSICAL EVIDENCE	
	▪ Clients receive ID cards with unique numbers for each client and their dependents. These ID cards include photos of the insured members (received upon payment of premium) ▪ Enrolment forms ▪ Check-in desks in the reception area of each participating hospital.
PEOPLE	
	▪ There is a Microcare check-in desk nurse posted at out-patient department of each provider facility ▪ These front line desk staff are all trained nurses to improve the quality of information tracked, the ability to explain issues to clients, and the ability to provide basic quality control over in-patient clients' care. ▪ The success of the product is highly reliant on the doctors and staff of the hospitals, clinics, and pharmacies with which Microcare works.
PROMOTION	
	▪ Word of mouth through marketers ▪ Brochures ▪ MicroFinance Institution front line staff ▪ Microcare senior management marketing to MFI senior management

	▪ Commissioned marketing staff ▪ The check-in desks themselves are promotional

Prevention:
The health care financier or insurer is often the stakeholder best placed to advocate for prevention of illness. Such activities can benefit the financier and the client. Microcare management notes that a large portion of their claims costs relate to cases of malaria. They are currently discussing possible ways to address this through distribution of insecticide-impregnated bed nets. Also related to prevention, the Microcare policy requires that in order for a woman to obtain maternity cover, she must attend at least three antenatal visits during the pregnancy.

An investment in prevention is one from which Microcare wishes to reap benefits (along with its clients). However, there is a concern that until the retention rate problem is addressed, any investment in prevention will be lost to Microcare if clients leave after only one insurance period.

INSTITUTIONAL STRUCTURE:
Microcare maintains two senior level departments: the Health Scheme Department (HSD) and the Technical Department (with 2 staff plus a manager). The HSD comprises a manager with Accounting (2 staff), Marketing (4), and Health Scheme Operations (7) departments. The overall Management Committee is comprised of the Managing Director and the head of the Technical Department, as well as managers of Accounting, Marketing, and Health Scheme operations departments. Departments and other management configurations are working under a recently introduced regular meeting schedule to improve communication and performance.

At the time of the visit, both the managers of the Marketing and Health Scheme Operations departments were relatively new. The marketing manager, with MFI marketing experience had been employed for one month. The Health Scheme Operations manager had been hired in December 2001, but was on maternity leave for three months before returning to the office a month before the visit. The Marketing manager replaces someone who was deemed ineffective by senior management. The Health Scheme manager is a new position resulting from recognition that there had been a serious lack of coordination and oversight in the institution. Microcare clearly recognizes the need to improve the quality of mid- to senior level management and these staffing adjustments result from that recognition. It was too early to assess the effectiveness of these new people, but their plans and actions so far point to an important improvement in Microcare operations.

Health Scheme Operations:
Microcare has spent considerable time, effort, and money in developing a software and heath care management system to create an effective structure for providing health care financing to the poor. The software system tightly controls access and coverage of clients at provider facilities selected for quality and customer demand. The system allows for continuous monitoring of many variables in order to manage the product from solid information about its client market. This system has been purchased by AON Uganda, a subsidiary of the international insurance broker AON because of its high level of controls in a market that has seen other health insurers bankrupt for lack of adequate controls.

The system includes nurses, selected for their basic medical knowledge, who approve all “transactions” by client patients. Though the implementation of this structure has several weaknesses, the structure itself is a good foundation for building and formalising a better-managed staff. With the new manager, this appears likely to occur.

Accounting:
The Accounting department has an accountant and an accounts assistant. However, neither of them have experience with accounting for insurance. The company has tried to manage with this structure but has recognised a need for a senior level management accountant to help them better manage the overall accounting for the health care financing business. More importantly, the company has recognised that it is essential to have someone with the capacity to analyse the results of operations, contribute to management decision-making based on accurate, timely, and insurance-appropriate accounting

information, and develop the department to bring it to a point where it is able to contribute to management in these ways. Proper accounting is not currently being conducted. For example, at the time of the June 2002 visit, books of accounts were completed only through 12/31/01, little to no accounting analysis was being conducted, and a rudimentary cash flow analysis process had just been instituted (by the health scheme operations manager). This is a serious impediment to proper management of this business.

During the visit, Microcare was enduring its annual audit for the period ending 12/31/01. In discussions with the on-site auditor, it was clear that the auditor had no experience with health care financing organisations and lacked the experience or knowledge to adequately review the books of such an institution. Among other issues, he was unable to assess risk in order to determine the adequacy of the reserves (which he did not recognise as important), and did not consider other particular accounting treatments for insurance premiums and claims. Such a lack of knowledge from an external auditor regarding low income health care financing is likely common among such institutions, but ultimately provides little benefit to the institution.

Cash flow was a serious problem for Microcare resulting from slow payments from other obligated entities. Payments to providers are averaging ninety days from the end of the month of service. We were unable to identify the period between invoice receipt and payment because there was no documentation on this. However, management indicated that some bills take up to two months to arrive while the hospitals note they are complete in days. Additionally, bills are occasionally incorrect as per the agreement and these issues need to be cleared before payment. It is Microcare's objective to pay providers within thirty days of receipt of an agreed invoice. However, a formal cash flow review, tracking, and projections had not been in place. A basic system has just been introduced.

In general, the institution is not being run based on accurate and timely accounting information and this must be addressed soon.

Marketing:
The Marketing department has recently experienced serious downsizing as they have gone from ten "marketeers" to three, and have replaced their Marketing manager. A lack of controls and structure in the department (among other things) has led to high dropouts (approximately 60% annualised for the prior six months), and actually, a decline in premiums collected (-5.5% for the prior five month period, August to December 2001, versus the most recent five month period, January to May 2002). The department now has a manager that appears to understand the need for structure and dramatic improvement of the marketing function within the institution. He has definite ideas about what he hopes to accomplish and he seems capable.

There is no formal marketing plan yet, and no formalised procedures, policies, or other guidelines for the staff in the field, but these were noted to be on the new manager's agenda. Microcare does have brochures (in English and Luganda).

Microcare marketing staff are generally provided access to the MFI partners' clients, with only the most basic support of the MFI front line staff. This limited involvement by the MFIs has been somewhat problematic. One institution allowed "only about five minutes" in their meetings for Microcare marketing. This proved insufficient and it became clear that clients had not fully understood what they had bought. To help mitigate this problem, and take advantage of an opportunity, another MFI has developed a new medical loan designed to provide their clients with an opportunity to borrow the premium amount and repay it over time.[2] These loan proceeds are paid directly to Microcare, and these loans have no impact on the level of the client's business loans.

Microcare has noted that MFI groups often respect their MFI front line staff and that when these staff are positive about the product, the clients are more likely to purchase. Additionally, the group leaders are said to be critical opinion leaders that have significant influence on their groups. If these people are convinced, a sale is more likely. Management noted that in one area where the leaders were enthusiastic about the plan, several complete groups joined. This can also cause problems, however, as "marketeers"

[2] The insurance coverage is for twelve months while the loan period is eight months.

found that when leaders owned clinics, drug shops, or other related businesses, they were averse to the plan.

"Marketeers" are paid a basic salary and are provided with a commission on premiums of 2% for new clients and 3% for renewals (which was just increased from 1% and 2% respectively).

Overall:
In general, Microcare has a very strong and adaptable computerised system for managing its health care financing plan. The structures and systems that surround it need formalisation, accountability, and strong and active management.

Some ratios calculated during the visit include:

- Insured to staff: At 31 May 2002:38.8 (776/20). This is a result of being geared up for growth which had to occur
- Administrative costs to Premiums: 1,318% (Jan - May 2002). Note that this includes the Microcare IT business administrative costs also which were not separated by Microcare in their books.
- Drop-out rate: 60% (Annualised for the prior March-May 2002, calculated as those dropped out over Feb 2002 clients plus new clients
- Claims to Premiums: Stagnant at approximately 70% from 08/01 to 05/02 except for Oct, Jan, and Feb (101%, 94%, 95%)
- Change in premiums written: (5.5%) (8-12/01 vs 1-5/02)
- Days of unpaid claims at 7 June: 89.5
- Reserves to claims: No reserves

Likelihood of Sustainability:
Though they have an excellent computerised system, Microcare has some serious operational issues to address. These issues have been discussed within this paper. From a profitability perspective, over the last ten months, three have seen premiums cover claims, and the others have shown close to an average of 70% coverage. The pricing has been adjusted during June 2002 by about 15%, but this is still unlikely to be sufficient to cover claims plus operational expenses, commissions, a reserve, and some level of surplus given their current client composition.

For the period 1 January to 31 May 2002, Microcare experienced claims of 136% of premiums (down 2% from the prior five month period), and administrative expenses (inclusive of commissions) to claims of 1,318% (up by 245% from the prior period). Management explains this deficiency of claims as related to significant adverse selection resulting from dropping their 60% minimum membership per group in order to try to increase insured numbers. Management stated that they have very recently returned to a firm adherence to their own policies.

Note that Microcare does maintain another business, health care financing IT, and they were unable to separate out these expenses, thus inflating the actual cost to claims. If we include the income from the IT operations, which at present is intentionally generated to support the health care financing operations, the administrative expenses to premiums and IT earnings for the 2001 and 2002 periods is approximately 300% and 450%, respectively. Even with this adjustment the point remains that much work is to be done to improve profitability.

Currently, Microcare receives multilateral, bilateral, and foundation support, as well as income from the IT activities to support the health care financing business. They are structured now to grow several times without the addition of any new staff (except a senior management accountant), with the exception of opening operations in new regions. The new premiums are unlikely to satisfy the needs of the institution unless adverse selection is better addressed, since at the current premium and with detailed experience data adding clients with the same risk composition are likely to simply increase the claims loss value (while maintaining a similar claims to premiums ratio). The response to the 15% increase, reported to be the fourth premium increase in the last year, was still limited at the time of the visit.

Although another premium change would be unpalatable, it would be beneficial to have a professional actuarial study conducted to help Microcare properly set its premium. The premium required to offer comprehensive coverage of Microcare expenses (the cost of care, plus operations, plus reserves) may in fact be too high to be affordable to the market they are trying to reach. Maintaining a product for this market may then require additional adjustments to the coverage/premium mix.

MANAGEMENT AND GOVERNANCE:

A five-member board of directors heads Microcare. Members include the Managing Director of AIG Uganda, a professional corporate secretary, a microfinance specialist, a microinsurance consultant, and the Microcare managing director. They are currently looking for two additional members to provide needed input in the areas of accounting and marketing or law. The board has had infrequent meetings, but has recently developed a regular schedule and appears to be following that plan.

The managing director is a physician with significant experience in Uganda working with health care financing programs.

PARTNERSHIPS

Microcare relies on two types of partners:

- Health service providers, for the provision of healthcare and
- Microfinance institutions, for access to significant volumes of customers who are not adversely selected.

Currently there are 5 approved health service providers – Nsambya, Kibuli, Rubaga and Kisubi hospitals, and Metromed clinic, all in Kampala. In addition, Microcare is also actively partnering with FINCA Uganda and works under a much less formal arrangement with, Pride Africa, Feed the Children, UGAFODE and the Uganda Women's Finance Trust. A grant from Austria, just finalized, will allow Microcare to commence operations in Kisiizi, in South Western Uganda, where they will already have 5,000 existing clients (taken over from another program).

At present, commissions are only paid to FINCA based on their newly developed contract. These are paid to the related credit officers. Commissions are not paid to the institutions.

In all the cases, Microcare initiated the relationships between them and the health care facilities and the MFIs (or other corporate entities). While the different partners did have expectations out of the relationship, these expectations/objectives have not been quantified. This would help in identifying clearly the achievements of this product with regards to the different entities. Both MFI and provider managements noted significant potential in the relationship and would like to enjoy an increasing volume of business with Microcare.

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

	PROVIDERS	MFIs
Objectives and Expectations	▪ Increased volume of business ▪ More insurance-based payments (minimising collection efforts) ▪ Increased income (based on timely payment)	▪ Increased client retention ▪ Better loan repayment capacity ▪ Improved client health ▪ Additional income (through commissions)
Relationship	▪ Generally satisfied but would like more prompt payment ▪ See a lot of potential and would like even greater volume of business from Microcare	▪ Want higher enrolment and more diligent marketing and follow up by Microcare

Roles Within the Relationship		
Partner role	▪ Provision of healthcare for Microcare patients ▪ Invoicing (takes up minimal time and capacity)	▪ Simply to give Microcare access to clients, ▪ Could do more through incentives ▪ Limited role hinders growth of product utilisation
Microcare role	▪ Marketing and training of clients and staff ▪ Payment (though this takes up to 120 days with some of the providers)	▪ Marketing and training of clients and staff ▪ Premium collection' ▪ Follow up
Capacity demands	▪ Minimal. Microcare business still less than 10% of total volume of provider business and providers still have excess capacity ▪ Invoicing takes up minimal time – 30 minutes to a day depending on efficiency of provider staff	▪ Minimal, since Microcare is responsible for marketing product and servicing it

CLIENT LEVELS OF SATISFACTION WITH THE PRODUCT

Generally, Microcare's clients report being satisfied with the product. They appreciate having access to good quality healthcare but their expectation is that their level of utilisation of the service should exceed the value of their contribution. It is evident that clients appreciate the role that Microcare plays in mitigating risk to their households. One client interviewed reflected the sentiments of many in saying that: "Now, we don't have to worry about what will happen to our families if they fall sick and we don't have any money to take care of them. I know that if my child falls sick suddenly, I can just walk to a hospital and get good quality healthcare even if I have no money on me."

While many of the clients genuinely joined in order to get a better quality of healthcare for an otherwise healthy family, several did indicate that they had joined in order to get coverage for known expensive ailments (this is adverse selection). A number of clients are responsible for ailing parents and for these, the exclusion of coverage for chronic conditions was an issue.

Several clients did complain that Microcare had prescription limits for the different drugs resulting in situations where a doctor may prescribed a drug, and the patient was left to pay a significant portion of the medications bill because only a portion of the prescription was covered. In some instances doctors prescribed drugs for a non-chronic condition that are also commonly used in the treatment of chronic conditions, and Microcare would not pay for them.

A number of clients had visited the hospitals over the weekend and had to pay for their treatment because the Microcare Check-in Desks at most of the hospitals are closed over the weekend. Many clients did not seem aware of what treatment options were available to them after hours and over the weekends.

There was general satisfaction with the providers though clients complained that one of the providers inflated treatment costs for Microcare clients. Staff attitudes were noted as being very poor. The general consensus was that hospital staff were often unfriendly and unhelpful. There were similar complaints from clients about Check-in Desk nurses who also often came in late, forcing clients to wait.

During the three months ending 31 May 2002, Microcare had an annualised drop out rate of 60%.[3] Clients attributed the low numbers of renewal primarily to:

[3] Total clients dropped out during the period/(total clients at end of February 2002 plus all new clients since then)

- A misunderstanding by clients about their ability to access care and medications for chronic illnesses, coupled with an exclusion for routine testing of these chronic illnesses.
- The fact that some people had not fallen sick over the period and felt that they had not received value for money.
- Difficulty in raising the premiums

While Microcare has experienced very low retention since late last year, there has been equally low growth. According to the clients, this was partly because of the reasons cited above but also because of:

- A lack of understanding of insurance and risk pooling by the market – people expect to get at least as much as they pay for and will therefore not join because they are not certain that they will utilise the service "enough"
- The cost of self-treatment and buying drugs in a shop, which is much lower than the registration fee (the co-payment) at an approved hospital

RISK MANAGEMENT:
Microcare has a strong focus on risk management and most issues are explained in some way relating to risk management. The computer system, the structure of nurses in the hospitals, the photo identification cards; are all manifestations of their efforts to maintain strong controls and limit the insurance risks that they face.

A major issue for Microcare is, however, a lack of any reserves to cover unplanned losses. They also have no reinsurance, and have sustained operational losses (covered by donor funding) since inception. This deficiency leaves Microcare with substantial risk and it is unlikely that they will be able to build reserves without the assistance of a third party. Although they have strong relations with AON Uganda, and through them the Insurance Company of East Africa (a regional reinsurer), as well as AIG Uganda (through their board chair), they have been unable to attract reinsurance cover. They are exploring ways that donors might be able to assist in developing a reserve and attracting insurance oversight and reinsurance.

In trying to build their numbers, Microcare made several accommodations to better enable clients to pay the premiums. Among these were allowing individuals to join and allowing installment payments (with treatment available after the first installment). These practices created significant additional risks of clients using the services and then not completing the installments, and of adverse selection. These accommodations have very recently been abolished.

The risk is technically borne by Microcare, although with no means to cover unplanned losses the *de facto* risk falls to the health care providers.

The risk management strategies employed by Microcare are noted in the table found in Appendix 1.

Risks to Partners:
Health care providers required a security deposit of at least Ushs. 1,000,000 (US$557[4]) from Microcare to cover any payment shortfalls. These amounts have not been reassessed based on actual usage. Also, at least one hospital noted a credit limit, though it did not appear that this was monitored by the hospital.

The MFIs were concerned about signing agreements with Microcare fearing that they may attract some of the insurance risk. MFIs do, in fact, shoulder some reputation risk in this relationship. Because the basic relationship of the client is with the MFI, there is potential that the client will blame the MFI if a problem occurs with the insurance. MFIs did not conduct any formal due diligence with Microcare to identify the potential risk they face.

At the same time, some MFIs requested that their logo be placed on the insurance card, which has the potential to cloud the distinction between the insurer and the MFI. This should be avoided because the distinction between the insurer and the MFI should remain clear in the eyes of the mutual clients.

[4] US$1 = 1795 Ushs (on 30 June 2002 http://finance.yahoo.com/m5?a=1&s=USD&t=UGX)

SWOT ANALYSIS

A summary of the strengths, weaknesses, opportunities and threats related to the Microcare program is outlined in the table in Appendix 2.

LESSONS LEARNED

Operations:

- Even with strong controls in place, patients will try to cheat the system. A good computer system needs to be in place that can very quickly generate data regarding policy renewals and current policies. Also needed are systems for harmonising drug prices between the insurer and the provider to ensure that provider staff do not inflate medical bills.
- The method of having the health care financing organisation maintain a desk at the providers' facility can greatly minimise the risk of fraud. With such a system, there needs to be effective supervisory controls to ensure that Check-in Desk personnel report on time and are fully available within working hours.
- A health care financing institution must develop and maintain reserves and relationships with an effective reinsurer. Without this, the institution is at risk, and all growth potential is stifled.

Marketing:

- Marketers are the growth engines of a health insurance operation. However, unless there is good supervision/control over marketers' activities and clear performance targets, the institution is unlikely to realise meaningful growth.
- The concept of insurance is still largely not understood by low-income people in Uganda. The marketing function of a health insurance provider needs therefore to put significant energy into educating people about insurance and how it works.
- Because of the competing demands for potential clients' resources, there must be frequent follow-up by marketers to ensure that people begin to plan and to set aside resources to renew their premiums when they expire.
- Misunderstandings are frequent when marketers or clients do not fully understand the products. This can result in client dissatisfaction, especially when clients do not completely understand how the product works and have unrealistic expectations with regard to the service they expect to receive. It is therefore important for a health insurance provider to invest in comprehensive training not just for the marketers but also for all partners' staff. They need to ensure that the product is well understood and well communicated so that clients do not develop false expectations. It is also important for the insurer to invest in developing standardised procedures manuals and training content. This helps maintain consistency of the message to clients.
- To ensure good customer retention and growth, an insurance operation needs to put in place adequate controls, objectives, and incentives for marketers to follow up on clients and ensure that they renew their policies.

Accounts:

- Like every operation that aims at being self-sustaining, a health insurance operation needs to have in place an efficient accounts department and a finance manager who is capable of interpreting the information generated by the department so that management can use this information to make useful decisions for the institution.
- Without the ability to quickly generate up-to-date customer information from the accounts department, a health insurance operation risks denying customers services to which they are entitled. In the case of Microcare, this function is supported by a strong MIS that has the capacity to quickly and easily generate client information and manage the client account, including automatically deactivate customers who have not renewed their policies.

Partners:

- Microcare's approach to service provision is through alliances with partner organisations over whom the institution has limited control. Without clear criteria for the selection of partners and

agreements that adequately bind partners to their roles, health care financing providers that use Microcare's approach to service provision could very easily have their reputation and the quality of their services affected by issues within the partner organisations. Thus, it is important to develop a criteria for selection of partners, and bind those relationships with at least memoranda of understanding.

Appendix 1: Managing Insurance Risks: Strategies used by Microcare in its Health Care Plan

Risk:	General Strategy:	Specific Strategy:
Moral Hazard	Pre-selected providers	Work only with five hospitals, one pharmacy chain, and one dental clinic
	Claims limits	Limit in-patient claims per period of payment to $195
		Limit in-patient time to three weeks in one period of payment
	Co-Payments	Co-payments ranging from $0.55 to $1.67 depending on time and facility of service.
	Loss review	Detailed review of claims
	Exclusions	Review can include assessment of treatment habits of individual doctors.
		Direct exclusions include intentional injury and wilful participation in acts of war.
	Waiting periods	Two weeks if outside regular enrolment period
	Proof of event	Insured must get pre-approval at Microcare registration desk before incurring claims costs.
	Client identification	Digital photo identification cards provided to each client.
		Client and family photo digitised and accessible on computer
	Pre-approval of treatment	Insured must be identified and receive billing sheet from Microcare registration nurse prior to receiving any insured treatment
	Expense verification	Monthly verification of expenses
	Deductibles	No deductibles required
	Initial exams	No initial exams required since pre-existing non-chronic conditions are not excluded
	Use of pre-existing groups	Insured are drawn from existing MFI clientele
	Prerequisites to care	Maternity benefits only provided if woman attends a minimum of three covered antenatal check-ups
	Membership from existing groups only	Insured are drawn from existing groups
Adverse Selection	Whole family membership required	Require client plus three, and then one at a time can join at a separate price for adults and children.
	Required membership within groups	At least 50% of group members (or 15 whichever is the most). In practice, this was not followed but has been reinstated very recently.
	Defined risk pools	Members of microfinance groups. No separation for business activity or other differential risk factors.
		Adults and children are priced differently with adults considered at higher risk.
	Waiting periods	Clients can only join with at least 15 or 50% of their group
	Tying insurance to other products	Insurance is tied to MFI loan product
	Periodic cost evaluation	Not done
Cost escalation	Preset pricing agreements with providers	Pricing agreements are made with providers (though this mostly takes the form of providers telling Microcare their prices).
	Preset drugs list	A pre-set drugs list is followed and notes included and excluded as well as limited coverage drugs.
	Co-payments	Co-payments ranging from $0.55 to $1.67 depending on time and facility of service.
Fraud and Abuse	Computerised ID systems	Photo ID with client and family is digitised and available at registration
	Coverage limits	Period of in-patient stay and amount of per illness coverage is defined
	Physical identification	Digital photo identification cards provided to each client.

Appendix 2: SWOT Analysis

Microcare, Ltd.: Institutional SWOT Analysis			
STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS**
Product			
Comprehensive	Hard for clients to understand	Very limited competition	Poor client understanding will lead to slow uptake and limited renewals
Provides access to quality providers	Communication to clients has been poor	Addresses an identified client need	Hospitals and MFIs have power to terminate the relationships leaving Microcare with nothing.
	Weekends and nights are not covered by Microcare staff causing client confusion	More hospitals are interested in this product if there is volume	
Operations			
Strong software systems	Historically limited field staff supervision		Raising nursing salaries at government hospitals might cause turnover issues
Recognition of needs for improvement	Lack of formal procedures		
Institutional structure will accommodate improved management			
Marketing			
Incentive structure for marketeers and (in some cases) MFI staff	Historically weak marketing with little follow-up	Very limited competition	Marketeers misinforming clients
New manager with credible plans to fix the department's problems	Historically weak marketing management - no controls or targets for marketeers	Access to clients through MFI and other groups	Without conveying an understanding of insurance, drop outs will remain high.
	Marketing focused on selling, but the product needs a training focus	Large potential market	Other insurers are potentially positioned to consider this market.
Accounting			
Management is working to address the serious problems	Lack of "insurance" or management accounting	Specialized software is available	Poor accounting will limit donor and reinsurer interest
	Very late financial reporting	Good relations with insurers might provide opportunities for training	
	Pricing procedures		
Risk Management			
Strong system	No reserves	Possibly through donor guarantees to insurers or direct grants	Lack of reserves has limited growth
Good institutional control structure	No reinsurance	IT business can subsidize insurance operations for the short term	Regulatory issues
Strong controls for insurance risks	Poor accounting		
	Prior limited control over field staff		

Appendix 3: Patient Flow at Hospital:

The following diagram details the process a covered patient must go through at the hospital or clinic to receive covered care. This example assumes that this is an outpatient visit requiring lab tests and medications, and is the most common covered activity. ("MTAC" refers to the Medical Treatment Access Card which clients are provided upon each hospital or clinic visit to track consultations, diagnostic procedures, and costs.)