

ANGLICAN HEALTH NETWORK'S MICRO HEALTH INSURANCE PROGRAM

TANZANIA 2009 – 2011

I. INTRODUCTION

During the past three years the Anglican Health Network (AHN) has been involved in conducting a pilot project to test the thesis that a faith based organization such as the Anglican Church could use its “brand” to become an efficient conduit for the distribution of micro health insurance to the poor in developing countries. This document traces the history of that pilot to document its genesis, assumptions, critical decisions, implementation, successes and failures. It is hoped that the documentation of this history and the accompanying evaluation of the pilot will serve as a learning tool for the AHN and others involved in this important and emerging field.

The Anglican Church is a worldwide denomination that includes eighty (80) million members spread across forty-one (41) provinces on six continents. One-half (forty million) of his members are located in the twelve (12) provinces of Africa. The Anglican Church provides outreach to its membership through a series of nine networks. The AHN was formed in the spring of 2009 following a proposal offered by Reverend Paul Holley, an Anglican priest in Geneva, Switzerland and Lee Hogan, retired chairman of St. Luke’s Episcopal Health System in Houston, Texas.

The organizational meeting of the AHN took place in Geneva in June 2009, with Reverend Holley and Mr. Hogan serving as Co-Chairs. Fourteen Anglican healthcare representatives from eleven countries attended that first meeting and adopted the following mission statement:

“The mission of the Anglican Health Network (AHN) is to renew the ministries of healing and healthcare within the Anglican Communion. It will transform the state of healthcare for millions of impoverished communities served by Anglicans in the developing world. It will promote learning and practice on the interactions between faith and health.”

Discussions about the implementation of that mission included consultations with representatives of the World Health Organization, the International Labor Organization, representatives from the Archbishop of Canterbury, the Anglican Consultative Council, USPG, the Global Fund, and a host of other entities. Those discussions identified the necessity of AHN maintaining an active role in all three fundamental elements of healthcare: education, prevention and clinical care. In order to be active in all of these domains, AHN decided to

incorporate both ‘networking’ activities that would draw disparate areas of the Communion into cooperative efforts and ‘programmatic’ components that would be coordinated by AHN.

In the latter category, the possibility of providing micro health insurance (MHI) to the poor had been raised even before the creation of AHN in the spring of 2009. Many observers of the developing world had noted the lack of access to healthcare available to the poor in those countries where they were trapped between the inadequate capacity of the public health facilities and the high costs of private hospitals and clinics. MHI had been advanced as a “second derivative” solution to this problem. Starting with the emergence of successful micro finance plans in the 70’s and 80’s, the world had long accepted the idea of the power of financial services for the poor. Beginning in approximate 2000 this concept was refined with the advent of micro insurance in which life, funeral and crop insurance was provided to the poor, usually in conjunction with a micro finance organization such as Opportunity International or Hope International. More recently consideration had been given to the more challenging second derivative or micro health insurance. MHI is more challenging than conventional micro insurance products for two reasons. The first is that instead of just involving two parties (insured and insurer), health insurance requires the integration of a third party – health care service providers. The second challenge is that serving the poor requires low premiums, and the cost of marketing and serving health insurance is inherently high. Nevertheless, the potential that MHI provided to renew the mission of healing and health in the Church encouraged AHN to investigate this possibility.

II. PRELIMINARY INVESTIGATION

Micro Health Insurance Investigation - AHN began its investigation into the potential of MHI in the winter of 2009 with a web based review of the literature available on the subject. Relative to other micro finance subjects, this literature was limited. It was clear that some attempts had been made to develop MHI for the poor in developing countries of Asia and Africa with mixed, and often poorly documented results. These attempts varied greatly in their approaches from outpatient savings plans to inpatient hospital based plans. The most successful seemed to have occurred in rural areas where they developed from micro finance plans as documented in George Halverson’s 2007 book Health Care Co-Ops in Uganda. There was no clear example of a MHI plan that had succeeded in a complex urban or metropolitan environment, apparently because of the two challenges cited above.

The initial phases of this investigation also made it clear that launching a successful MHI program would require the fulfillment of three very independent functions, illustrated in the following chart:



AHN was attracted to this organizational structure because it offered a faith based organization the opportunity to play the key role of the front office / marketing entity. AHN was aware that the Anglican Communion had a strong numerical position on the continent of Africa, with 40 million of the Communion's 80 million members located there. It was also clear that these numbers were increasing, and that the Church enjoyed a strong bond and credibility with its members there. However, to convert this asset into a viable MHI program, AHN would need to find entities capable and willing to play the other two roles.

Underwriter Search - AHN's first steps were to try to locate organizations willing to play the role of Risk Taker / Underwriter. We established that priority because it was clear that the Anglican Church did not possess the financial resources to fill this role. Initially we contacted established underwriting organizations in the U.S. and Europe including Aetna, Humana, Blue Cross, CIGNA, Munich Re and Swiss Re. Each of these organizations expressed interest in the concept of working with a faith based entity such as the Anglican Church, but none were willing to participate in such a program for native populations in the developing world.

MicroEnsure Relationship - Faced with that reality, AHN turned its attention to locating an entity to play the role of back office / claims. Although several organizations are entering this area, key players in the space such as Michael McCord at The Microinsurance Center and

Craig Churchill at ILO recommended we first contact MicroEnsure (ME). ME is a subsidiary of Opportunity International that was formed in 2005 to investigate the field of micro insurance. ME is headed by Richard Leftley who has a distinguished career in insurance including a number of years at Benfield Greig Ltd in London before joining Opportunity in 2002. At the time AHN contacted ME, they already had significant experience in the micro insurance fields of life and crop. Policies covering those risks were being marketed by ME through offices in Ghana, The Philippines, Uganda, India and Tanzania.

In addition, ME had developed relationships with insurers and reinsurers across the world including a long standing history with the Hollard Insurance Company operating out of Johannesburg, South Africa. Hollard had a stated goal of trying to increase their presence in the African market.

Mission Adopted - Based upon those preliminary investigations and experiences, AHN and ME jointly decided to pursue a project that would test the following hypothesis:

That a faith based organization can enable a viable micro health insurance plan for the poor by providing through its "brand" an efficient and economical conduit for marketing and sales.

This hypothesis was further enforced by the sub-mission that AHN adopted to guide its work in MHI:

"The AHN, representing the Anglican Church's traditional mission of healing, seeks to improve the health of poor Anglicans, and others living in communities with a significant Anglican presence, by providing financial resources through a MHIP that will allow those covered access, that they could not otherwise afford, to professional healthcare for their most pressing health challenges."

Armed with those missions and hypotheses, AHN began its serious investigation of the feasibility of faith based MHI by codifying its relationship with ME in a memorandum of understanding executed in August 2009. This MOU assigned to AHN the following responsibilities for the project:

1. Project Leadership
2. Selection of Project Location
3. Access to Clients for the Purpose of Market Research

In turn, ME was assigned the following responsibilities:

1. Market Research
2. Establish Contractual Relationship with Qualified Underwriter
3. Product Design
4. Claims Handling & Back Office Functions

These responsibilities were expanded, in January 2010, to clarify that AHN was responsible for marketing, sales and brand promotion; and ME responsibilities included creation of the service provider network.

Anglican Church in Africa - In September of 2009, representatives of AHN and ME attended the meeting of the Council of Anglican Provinces of Africa (CAPA) held in Nairobi, Kenya. That meeting included nine of the twelve Anglican Archbishops of Africa, and representatives from the other three provinces. AHN and ME jointly presented the concept of MHI to that assembled group. The concept presented to that meeting included the following elements:

1. A health policy that would cover malaria and possibly maternity inpatient costs
2. A premium that would be \$20 - \$35 per year for a family of five depending on whether maternity was included
3. An annual maximum benefit for the family of \$500 per year

The reaction of the CAPA members to this concept was overwhelmingly positive. All agreed that maternity and malaria were the most significant risks facing their members from both a health and financial perspective. Many also indicated that they believed such a plan could be paid for by the individual parishes that would then collect the premiums from their members. Finally individual archbishops from Kenya, Tanzania and Central Africa all encouraged AHN to test the MHI concept in their provinces first.

III. PILOT SITING AND DESIGN

Siting Criteria - The decision as to where to test our hypothesis in a pilot program involved consideration of a variety of factors including:

1. Strength of Church Leadership
2. Compatibility of National Legal Structure to micro insurance
3. Availability of service providers to populate a network
4. Willingness of underwriters to participate in the country
5. Disease prevalence and cost to treat
6. Effectiveness of national health insurance plans in the country

Initially AHN considered Malawi, Kenya, Uganda, Tanzania and Botswana as possibly meeting those criteria. Ultimately, Tanzania was chosen for the following reasons:

1. The Anglican Church of Tanzania includes approximately 4 million members which is the third largest population in Africa behind Nigeria and Uganda. The Archbishop of the Province of Tanzania, Valentine Mokiwa is also the Bishop of the Diocese of Dar es Salaam. He is a highly regarded figure in the Church, and a strong supporter of AHN and the MHI plan. The General Secretary of the Province was at that time Mwita Akiri, a strong voice in the Church and a member of AHN's Advisory Council.
2. Tanzania has long had a strong micro finance industry, and its laws are conducive to the capital structures and operations of micro organizations.
3. The Diocese of Dar es Salaam includes more than 400 hospitals, clinics and dispensaries and the nation's best public hospital and medical school. It was felt that this spectrum of medical service providers would make the creation of an attractive service provider network more feasible than would be possible in a rural setting with fewer providers. (see discussion of future expansion in Section III)
4. Hollard Insurance was very interested in establishing a position in the Tanzanian market, and ME had an existing relationship with the Golden Crescent Insurance Company in Dars that was willing to act as Hollard's local underwriter.

5. Tanzania had a relatively low HIV infection rate (4%) and government programs to test for and treat HIV and TB.
6. Tanzania has a national health insurance plan, but it applies mainly to government workers. In addition, the government has run a rural community health scheme for 10+ years that has struggled to gain traction. Reliable estimates indicated that the government programs covered 3-4% of the population.

Tanzanian Due Diligence - Having selected the Diocese of Dar es Salaam in Tanzania to conduct the pilot, AHN and ME began a more in depth investigation of the market. Meetings were held with the Chief Medical Officer of the Health Ministry, the Commissioner of Insurance, the National Director and Chief Medical Officer of the World Bank in Tanzania, the Director of The Christian Social Services Commission, the Director of the Roman Catholic Clinics of Dar es Salaam, the National Bureau of Statistics, and physicians throughout the Diocese in meetings coordinated by Drs. Lugajo and Mwandolela of Mumhimbili Public Hospital.

Following those meetings ME led the effort to produce a definitive study of the medical and financial conditions in the diocese that would impact the proposed MHI pilot. The results of that study are included in the ten page study included with this report as [Attachment 1](#). Results reflected in the report includes information gained from interviews with 74 church leaders from 9 parishes and medical professionals from 58 of Dar es Salaam's 476 hospitals and clinics. It should be emphasized that the data developed in this report played a key role in the ultimate development of the product tested in the Tanzanian pilot.

The next step in the investigation was a series of "focus groups" including clergy, lay members and physicians at 16 locations across the Diocese. These meetings were held to gain input on three crucial questions:

1. What diseases are creating the greatest health and financial burdens?
2. How much are poor to middle class parishioners spending annually on healthcare?
3. How much could a family of five afford to pay for malaria and maternity coverage with an annual maximum of TS 750,000 or \$500?

The answers produced at these sessions can be summarized as follows:

1. Malaria is far and away the condition that most affects this class of people. After malaria there was a significant dispersion of opinion with maternity, children's

diarrhea, hypertension, pneumonia, diabetes, typhoid and trauma all being mentioned.

2. It was difficult to get answers about annual expense history, since few, if any, households kept accurate written records. However, anecdotal data gained by listening to participants dialogue among themselves indicated that a range of TS 75,000 to TS 900,000 (\$50 - \$600) captured most of the experiences.
3. When asked directly how much a family was willing to pay for reliable health insurance that would cover malaria and maternity costs, most responses ranged from TS 30,000 to TS 50,000.
4. It should be noted that past experience in such surveys has indicated families often over state expenses and understate income, making the 'affordable price' more difficult to calculate.

Product Design - Taking the input gained from all of these sources, AHN and ME began the task of designing a product for the pilot test. This design stage began in the late spring of 2010 and continued through the late summer. Options debated included:

1. *Whether to include outpatient care as well as inpatient?*

Because of our desire to include prenatal care for pregnant women, and early diagnosis for diseases such as malaria, we opted for the combined inpatient / outpatient coverage.

2. *Whether to cover all conditions with a lower maximum or specific condition with a higher maximum?*

This was perhaps the most difficult design decision. The arguments covering all conditions included the multitude of conditions cited during the "focus groups", the difficulty in covering patients with co-morbidities, and the confusion over what was or was not covered. Initially we elected to present a policy that covered only malaria and maternity. The reason for this selection was to keep the annual premium within the range that we felt even the poorest of the working poor (average annual salary of TS 600,000) could afford. After this design was publicized, however, there was significant criticism from the clergy and we ultimately opted for a design that included diarrhea and respiratory diseases as well. The result of this increased coverage was the higher premiums described in Section IV.

3. *Whether to base the revenue model on a diagnosis, fee for service or capitation model?*

The capitation model was particularly attractive because it provides a healthcare provider with an incentive to keep patients as healthy as possible. However, in the environment of Dar es Salaam, where there are no multi-disciplinary practices, but many competing physicians and hospitals, we concluded that a revenue sharing model would be difficult to manage. Similarly, the idea of a fee for service model was rejected because we felt that auditing the services actually provided would be very difficult. Therefore, we elected to use a diagnosis related reimbursement plan whereby we negotiated reimbursement to the healthcare providers based on the condition diagnosed.

4. *Whether to have a single premium for all participants or a multi-tiered system where the more affluent could pay a higher premium for a higher level of benefits?*

Specifically we discussed a three tiered system with the concept that the higher tier would provide a higher margin thus allowing us to subsidize, or lower, the lowest rate to assist the poorest in the community. Ultimately, we opted for the single premium model based on the belief that a simpler approach was best for the pilot phase.

5. *Whether to have a minimal co-payment to discourage overuse of the plan?*

We decided that marketing to a universe (Anglican parishes) that had no built in “adverse selection” was sufficient protection from overuse, and thus elected not to include a co-payment. We were also influenced in this matter by wanting to encourage participation in the plan in an area (Tanzania) where insurance is still a novel concept. There was also concern that a copayment might cause patients to delay treatment thus increasing the severity of the condition and the cost to treat.

6. *Whether to include education and prevention material in the program?*

Specifically we considered making the distribution of malaria testing kits and mosquito netting mandatory for all participants. Ultimately, we were persuaded that other entities were engaged in these efforts to a sufficient degree in Dar es Salaam. However, these activities may be considered in more rural settings in the future.

7. *Whether to market through the Anglican Church exclusively, include other denominations or include non faith based organizations such as hospitals and clinics?*

It was always the intention of both AHN and ME to make this product available through all of the Christian denominations in the Dar es Salaam area that wanted to participate. While we wanted to begin in the Anglican Church where we had access and the support of the Archbishop, we also had early conversations with the Cardinal of the Roman Catholic Diocese of Tanzania about expanding to his

church when and if the premise was validated. It was clear that if it could work in the Anglican Church it could work in others.

We were also clear that we could consider distributing a MHI product through other organizations, such as labor unions; so long as those other organizations did not, of themselves, present an adverse selection issue.

The question of distributing through hospitals and clinics was considered more complicated. First ME was already involved in a hospital based plan with the Church of South India, and it was hoped by using one approach in India and a separate one in Africa, we could compare approaches. Secondly, the issue of adverse selection is always a concern when hospital channels are used, as their normal population comprises an abnormal number of chronically ill. Finally there was a concern that hospitals might be marketing the program for a different primary purpose (hospital profitability) than the church. Thus, we decided to initially limit the market channel to the Anglican Church.

It should be emphasized that in defining this scope for the pilot, it was the clear intent of AHN to ultimately expand this concept, if validated, to the following markets:

1. Other denominations in Tanzania
2. Progressively more suburban and rural settings in Tanzania to test the density of clients and service providers necessary for success and to consider other structures (capitized plans) in these areas
3. Other Anglican Provinces in Africa, Asia and Latin America

Anticipated Challenges - In planning for the pilot in Tanzania, we anticipated that a number of different issues would constitute challenges and potential problems for any MHI plan. Among the issues that were anticipated were the following:

1. Data- the difficulty of securing reliable data extended to accurate population figures for the Anglican Church in Tanzania, accurate figures for disease prevalence and accurate figures for the cost of treating disease conditions. Illustrative of these were the fact that the Anglican population of the Diocese of Dar es Salaam was variously estimated by church official from 20,000 to 120,000, and the prevalence of malaria in Tanzania included estimates as wide as from 3% to 40% from the WHO and Tanzanian Health Ministry.

2. **Ignorance of Insurance** – while some forms of insurance have existed in Tanzania for a number of years, the concept of “risk sharing” is still very new. Many of the focus group participants asked questions such as “do I get my money back if I don’t get sick?”, or “where does my money go if I don’t have a claim?”.
3. **Reputation of insurance** – several of the previous insurance programs in Tanzania including both private and government had either failed or not met expectations, giving the entire industry a negative reputation.
4. **Cash precedents** – a number of service providers in Tanzania had operated on a cash basis, where patients paid in advance to receive treatment. Such providers were reluctant to move away from this model.
5. **Maternity practices** – some service providers in Tanzania had a policy of refusing maternity care to mothers expecting their first child in the belief that such deliveries were often more difficult and expensive. In many cases service providers did not have proper facilities for dealing with high risk pregnancies.
6. **Cash integrity** – there were many concerns expressed that the churches were ill equipped to collect cash, account for it, separate it from their normal accounts and deliver it reliably to an insurance program.
7. **ID production** – one of the key elements to any health insurance program is the ability to quickly and accurately determine who is covered and who is not. Hence the need for a reliable ID system that a covered individual can use to establish their insurance status with a service provider. There are many such reliable systems including the biometric systems of finger prints and retina scans. However, these devices are relatively expensive, costing approximately TS 12,500 (\$8) each, and presenting a different set of ID management challenges. Such a cost would push the premium to unacceptable levels, and therefore we adopted a practice ME had used in India of manufacturing IDs from a single photo showing all five covered members of a family.
8. **Disease definition** – the prevalence of malaria in Tanzania is so high that many people assume any fever is a symptom of the disease. Thus, any insurance policy that states that it covers malaria, faces the challenge of treating every fever or being perceived as not meeting its contractual obligation.
9. **Fraud** – the risk of fraud is present in several aspects of a MHI plan. The first is ID fraud if clear proof of coverage is not available. The second is fraud by service providers in diagnosing conditions to assure insurance coverage.
10. **Costs & Availability of drugs** - with the exception of ARV’s for the treatment of HIV, many drugs are in short supply in Tanzania, and thus black market prices can be high (See pharmaceuticals – Section IV).

11. **Provider Preference** – customers choose hospitals rather than dispensary level providers for primary care services, thus raising costs. They may also prefer higher costs facilities than the premium level can justify.
12. **Provider Quality** – guaranteeing quality across a dispersed group of providers (who are really the HMI’s product) with various definitions of quality may be difficult.

IV. MHI PILOT PROJECT PHASE 1

Pilot Policy Provisions - Having completed our preliminary investigation, and made the key decisions around location and design issues, the pilot project was launched in the fall of 2010 in 21 of the 44 parishes in the Diocese of Dar es Salaam. We estimated that some 20,000 Anglicans attended these 21 parishes. The product that was offered is summarized as follows:

1. Inpatient and outpatient coverage for malaria, maternity, diarrhea and respiratory disease was provided.
2. Premium of TS 60,000 per year paid in one or two installments was set.
3. During the pilot a second premium option of TS 30,000 per year was offered for college students living away from their families.
4. Maximum benefit was stated as TS 600,000 (\$400) as required by Tanzanian law, but options were discussed that would assure needy families would receive the care they required.
5. Eligibility was originally set at age 65 and below, but later changed to 70 at the request of parish elders.
6. Participants were required to initially be treated at one of 14 clinics distributed geographically throughout the 21 parishes. However, patients referred to specialty hospitals not in the network would also be covered for those costs.

Staffing – ME already had an office and staff in Dar es Salaam, and had been engaged there in the sale of life and other insurance products. The start of the MHI pilot with AHN allowed ME to add a country manager, Ryan Lynch, a graduate of the Harvard Business School who had previous experience in the Uganda market. ME also added Josef Tayag, a recent graduate of the Harvard School of Public Health, to coordinate the creation of a service provider network. In addition ME employed a number of Tanzanian personnel with sales and claims experience in Tanzania.

AHN, with more limited financial resources, hired a part time country manager to coordinate the network's responsibilities. Japhet Makau, a native of Tanzania was chosen for this position. Japhet has a business degree from the national university and extensive experience in micro finance for several large banking organizations in Tanzania. In addition, Japhet has been extremely active in the Anglican Church in Tanzania, including heading the effort to start a "church bank", and he has a very strong relationship with Archbishop Mokiwa and many of the Anglican clergy in Dar es Salaam.

Underwriting – ME had a long established relationship with the Hollard Insurance Company of Johannesburg that predated this pilot. They had kept Hollard informed as plans for the proposed MHI pilot progressed, and when the decision to go forward was finalized, ME entered into an underwriting agreement with Hollard through ME's Tanzanian partner, Golden Crescent Insurance. Under the terms of this agreement, Hollard and Golden Crescent assumed all liability for the payment of claims generated by the program. In addition, representatives and actuaries of Hollard & Golden Crescent participated in the product design and premium setting described above.

Economics – The economics of the pilot were predicated on an anticipated loss ratio of 65 – 70%. This estimate was very uncertain due to the data problems cited above concerning disease prevalence and costs to treat. Nevertheless, it represented the best calculations of the combined work of ME and Hollard/Golden Crescent. In addition, ME entered into a brokerage agreement with Hollard/Golden Crescent that provided ME with a brokerage commission of 20% of premiums collected. This 20% was intended to cover all costs of marketing, sales, ID production, service provider network creation, service provider auditing, claims handling and accounting. AHN in turn, through its memorandum of understanding with ME, was a subcontractor to ME with responsibilities for marketing and sales. It was agreed that the 20% brokerage fee paid to ME would be divided between ME and AHN based on their respective costs.

Pharmaceuticals – ME discussed a program through Pharmaccess in Amsterdam to furnish adequate drugs and pharmaceuticals at discounted prices. Although this arrangement is a future possibility, it was not put into effect for Phase 1 of the pilot.

Service Provider Network – When the initial decision was made to include 21 parishes in the pilot, AHN and ME worked together to identify those service providers that would provide the best service to the targeted market. A preliminary list of 24 hospitals and clinics were identified using the following criteria:

1. Geographic location
2. Mixture of clinics, primary care hospitals and referral hospitals

3. Reputation for quality
4. Names specifically mentioned as desirable during preliminary focus groups

ME then started contacting these prospective providers to enroll them into the program. Advantages cited for participating included increased source of patients, reliable and efficient payment of claims and technical assistance to improve care quality. Ultimately, only 14 clinics and hospitals participated, and none could be considered a referral or advanced care facility. However, higher level facilities (including Muhimbili, the nation's highest level hospital) were available to participants whose condition required these more sophisticated facilities. In such cases the costs of the referral to a non-network hospital would be covered if medically necessary.

One of the 14 was an Anglican clinic and the balance was Roman Catholic or secular. The Roman Catholic Church was particularly helpful in providing access to their clinics and hospitals in the area, and agreed to join through a "standard" contract that was the starting point for discussions with all Roman Catholic facilities.

Reasons cited by hospitals and clinics that did not join the network included:

1. No history with AHN / ME project or parties
2. Reluctance to try a system that didn't provide cash payment in advance of treatment
3. Unwillingness to accept payment schedule proposed by AHN / ME, especially in the area of maternity care
4. Reluctance to populate hospital with "poor, smelly patients" who would drive away better paying patient populations

Ultimately, it was decided that the 14 hospitals and clinics that did agree to participate represented sufficient geographic coverage and quality to proceed with the pilot.

Marketing and Sales - The original budget agreed to by AHN and ME for the marketing and sales activity was TS 36,175,000 (\$24,100). This budget was later increased to approximately TS 70,000,000. This amount was intended to cover only sales and marketing of the plan, not the cost of creating the service provider network, the claims handling or the accounting function. During the course of the pilot, Phase 1, this budget was approximately doubled with the full realization that such an expenditure could never be repaid through the brokerage fee estimated. It was believed, however, that the primary purpose of the pilot was to confirm the premise stated in Section II, page 4, of this document, and that breakeven economics would

be established as the volume of policies increased. The marketing and sales effort included the following components:

- 1. Branding – It was believed that although this program was to be initially distributed through the Anglican Church, that it would ultimately be an ecumenical program if successful. Therefore, we concluded that while it was important to explain to the members of the Anglican Diocese of Dar es Salaam that this was a program supported by the Anglican Church, it was equally important that the program be branded in a way that would not limit its appeal to Anglicans. Therefore the program name “Imani” was selected which is a Swahili word with multiple positive meanings including trust and working to help one another. All written material for the pilot, including the policies themselves, incorporated this brand.**
- 2. Clergy Involvement – Individual meetings with the clergy from each of the 21 parishes were held to explain the program, identify the service provider closest to their parish and to explain the benefits to the parish of a program that would improve the health of their members.**
- 3. Launch Publicity – In September 2010 an “Imani Celebration” was held to announce the kickoff of the pilot program. Each of the 21 parishes was invited to participate in a choir competition that was held at a central location in Dars. At that celebration, Archbishop Mokiwa announced the start of the program and his strong support. In addition, AHN and ME were present to explain the details of the Imani program including coverages provided and a proposed schedule for visiting each parish.**
- 4. Media Publicity – AHN worked with news media in Dars to place stories about the beginning of the Imani Program. The Imani Launch Celebration was covered in both local TV and newspapers. However, it was not to place future ads in newspapers or electronic media because the target market of the Anglican Church made such media not cost effective.**
- 5. Service Provider Monitoring – Originally AHN and ME had discussed using a third party administrator (TPA) to monitor the performance and billing of the service providers selected for the pilot. Once Tanzania was chosen, however, it was decided that that function would be performed by ME personnel working from an audit of claims forms files and reports of problems from covered clients. The most frequent problems involved misunderstandings about the provisions of the policy**

or the proper interpretation of the billing procedures using the diagnosis method. The vast majority of these problems were resolved in consultations between ME and the service providers.

6. **Sales Representatives – Actual sales responsibilities for the program were carried out by paid sales representatives (SR's). Working through an extensive interview process, 15 SR's were selected by Japhet Makau. Each SR was a college graduate, bilingual and demonstrated aptitude for the position. The SR's were then put through a formal training program including provisions of the Imani product, sales techniques, and provisions for registering & handling the cash of enrollees. Each SR was offered a bonus payment based on the number of sales they recorded. Following the training program, SR's were assigned to specific parishes in teams of one or two. Japhet then took each team to their assigned parish where they were introduced to the clergy, parish elders and members of the Mother's Union.**

At each parish the SR's began a series of meeting with Mother's Union members, choirs, prayer groups and other organized gatherings that took place both on Sunday and throughout the week. At each of these meetings the Imani Program was explained and questions answered. Families who thought they would be interested in participating in the MHI program were asked to sign a list indicating such interest. Approximately 800 families signed these initial indications of interest.

Finally, posters were displayed at key locations at each parish announcing the program and scheduled dates for registration.

7. **Registration Process – Following the education process of parishioners described above, two registration Sundays were scheduled for each parish. Those dates were announced in advance from the pulpit, and posted on parish bulletin boards. All parishioners who wanted to enroll in the Imani program were advised to bring a picture including the five people they wished to cover and TS 30,000 or 60,000 (\$20 or \$40) to complete their registration. Cameras were provided for each parish to assist those who did not have an existing picture or camera.**

At each parish, an "Imani Tent" was erected outside of the church, and parishioners were invited to stop by the tent following church services to turn in their photo, pay their premium and complete the short application form. In many

cases the SR's also came back during week nights to various church meetings to secure applications.

8. **Goals -** The obvious goal of the pilot program during this first phase was to register as many participants as possible. Based on the focus groups, the pre-registration that had taken place and input from the clergy at the 21 parishes, AHN and ME had hoped to register between 750 and 1500 families during this first phase. In addition, it was decided the pilot would be evaluated based on the following criteria:
 - a. Sales levels achieved
 - b. Client satisfaction with the program based on a survey of covered parties after six or twelve months
 - c. Service Provider satisfaction based on a survey of service providers after six or twelve months
 - d. Economic viability of the program based on the loss ratio experienced
 - e. Improvement of the health of participants, although it was recognized that this criteria could not be measured until reliable base lines were established over a longer time period

V. Phase 1 Results

The implementation of what is now referred to as Phase 1 of the pilot began the first week of October 2010 and continued through the end of the year. All 21 of the target parishes were approached using the marketing and sales approach used above. The results of the Imani program over that registration period and continuing through the first quarter of operation can be summarized as follows:

1. Family enrollment reached 196 and single student enrollment reached 198 for a total of 1178 covered lives.
2. The loss ratio as of March 31, 2011 was an annualized rate of 148%. This figure was skewed somewhat by very high initial usage from the student population which had begun to subside by the end of March.
3. The frequency of maternity claims was very low – less than 20. Anecdotal evidence suggests that this low claim rate may have been caused by families not enrolling in the plan until after the birth of children. The Imani policy of not allowing the addition of covered parties during the policy period may have had the unintended consequence of making this the only way to insure new borns.

4. The largest operational problems came from two sources:
 - a. Covered persons who didn't understand that coverage was limited to the four specified conditions
 - b. Service Providers double billing for patients whose diagnosis might include more than one of the covered conditions

Analysis of Results – Because the enrollment rates were so far below anticipated levels, AHN and ME engaged in diligent efforts to understand the reasons for these differences. The first of those efforts involved an informal collection of views from those most involved in the program as to why the underperformance had occurred. The following is a summary of the views expressed by one or more parties through that process:

1. Church leaders, particularly parish leaders, were concerned that money taken out of the parish for the Imani program is money that could have otherwise been used for salaries or other parish uses. This feeling was also reflected in the observation that parishes had not taken “ownership” of the Imani product.
2. Potential clients had no experience with Imani, and were not convinced that the program would meet its commitments. In some ways this reflected the fact that insurance was new to Tanzania, and previous insurance programs had not performed well.
3. The SR's used were good at relating to potential clients and explaining the program, but were not experienced sales personnel with “closing” ability.
4. The service provider network did not contain all the providers the clients wanted especially in the referral hospital category.
5. The pilot launch was not well coordinated with the equipment to produce ID's not arriving until well after the program started,
6. Potential clients wanted a product that covered all diseases and injuries.
7. The campaign needed print and electronic media ads to establish credibility.
8. Sunday services were a bad time to conduct enrollment as there was too much else going on, and people wanted to get home after the service concluded.

While this list of potential problems was compiled by individuals that were very familiar with the Imani Program, and had played a key role in its conception and execution, AHN and ME both felt a more formal market survey was necessary to determine why the product acceptance had not met expectations. Accordingly we decided to conduct a survey of a representative group of those families which had initially indicated an interest in the product, but did not purchase a policy. An independent third party was hired to conduct the survey which was completed by 65 such families. It should be emphasized that the third party only

conducted the survey, the design was a product of AHN and ME. The results of that survey are included as [Attachment 2](#).

The results of this survey clearly indicate that those surveyed understood the basic provisions of the Imani policy and that it was a program supported by the church. They further indicate that they felt the product was priced at a fair and affordable level.

On the other hand the respondents clearly expressed two concerns about the program:

1. A lack of history and credibility in the community
2. A concern that not all desired hospitals and clinics were in the network
3. In addition to these two points highlighted in the market survey, subsequent discussions with clergy in Dar es Salaam also revealed that there was considerable concern expressed that the Imani product was appropriate only for the very poor. It was suggested that a multi tier product providing higher levels of benefits for higher premiums might attract more clients and improve the image of the product among parish leaders.

V. Imani Phase 2

Based on both the results and the analysis of Phase 1, it was determined to conduct a second pilot in the Diocese of Dar es Salaam that was designated as Phase 2. After considerable discussion the following changes were made to the Imani Program for Phase 2

Parish Ownership - To reduce the feeling that Imani was a program owned and conducted by someone outside the parish and then imposed upon the parish, the approach was modified to give the individual parish a greater sense of ownership of the program. To many familiar with work in developing countries this new approach is similar to what is often classified as the development approach. The change was addressed in the following ways:

1. A group of 15 of the Diocese's 44 parishes were initially identified to take part in Phase 2. Some of these parishes had participated in Phase 1 and some had not. The 15 were selected as the most likely to have high acceptance rates in Phase 2 based on input from AHN, ME, the SR's participating in Phase 1 and clergy.
2. The financial structure of the program was changed so that participating parishes could earn an incentive of 5-10% of the premium for each policy sold in their parish. Such an incentive was far in excess of what was paid to SR's in Phase 1, and the pro forma consequences of this payment are reflected in the budget for Phase 2 shown in [Attachment 3](#). The attachment, which was prepared to show the

- impact of rolling the program out to all 40+ parishes shows that more than 25,000 policies would have to be sold to reach breakeven using this model. As was the case in Phase 1, AHN and ME realized these economics would ultimately have to be modified, but wanted to conduct a test with this high level of incentive to see the impact on sales.
3. Each of the 15 were approached individually by AHN. The clergy and elders were briefed on the Imani Program, the results of Phase 1 and the changes for Phase 2. They were asked to sign a document indicating their willingness to conduct the Imani Program in their parish.
 4. Each parish was asked to designate a parish representative (PR) to coordinate the program for their parish. These PR's, in effect, replaced the SR's used in Phase 1, and would become the face of Imani in their parish. AHN encouraged each parish to choose a PR that was respected by the parish, had sufficient time to devote to the program and had the energy, education and initiative to be successful. Each parish was given the option of paying some or all of the sales incentive to the PR.
 5. AHN and ME conducted training programs for each PR similar to those provided for SR's in Phase 1. In addition sales support material including posters and brochures were distributed to the PR's. Finally, representatives of AHN and ME agreed to appear with the PR's at any parish events where the PR requested their assistance.

Anglican Church Support – Archbishop Mokiwa continued his strong endorsement of the program in Phase 2. However, the Imani Program shifted its emphasis from the diocese to the archdeaconries for direct support. The Diocese of Dar es Salaam has three archdeaconries with 10 to 20 parishes each. These archdeacons are closer to the parishes, clergy and members, and they have more time to devote to promoting the Imani Program than the Archbishop who is responsible for the entire country of Tanzania.

Credibility of Imani – The following steps were taken to increase the credibility and reputation of Imani to the parish members:

1. Ambassadors were identified from Phase 1. These were individuals that had joined the Imani Program during Phase 1 and filed one or more claims. They were individuals known to AHN and ME to have been very satisfied with their Imani experience and the treatment they had received by Imani service providers. One or more of these Ambassadors were taken to the 15 parishes participating in Phase 2, and spoke of their satisfaction with Imani at a scheduled Sunday service. It should be noted that identification, training and execution of parish visits for these

Ambassadors was challenging due to the variety of scheduling and logistical issues in Dar es Salaam.

2. As outlined in [Attachment 3](#), budget provisions were put into Phase 2 for the option of using print and/or electronic media support. This could include both print and electronic media to support the concept that Imani was a substantive program.

Service Provider Network - Although Imani was faced with the same challenges in Phase 2 that it faced in Phase 1 in recruiting the most advanced, referral hospitals into the network, ME continue its efforts to expand the network to meet the perceived needs of the Phase 2 parishes. In addition, just as we did in recruiting Ambassadors to speak to the parishes about their positive experiences during Phase 1, we recruited representatives from the hospitals and clinics participating in Phase 2 to speak at the parishes about the ease of use Imani at their facilities and the capabilities of their facilities that might not be well known to the parishioners.

With these changes to Phase 1 in pc, Phase 2 of the Imani Project was launched in July 2011, and was continued through September 30, 2011. Twelve parishes participated in Phase 2, including signing an agreement stating their willingness to participate and their agreement to appoint and support a “parish representative” to lead the program in their parish. There was significant variety in the individuals appointed by their parishes to these positions including education, time available, profile in the parish and commitment to the Imani Program. The efforts of these parish representatives were augmented to a significant degree by training, printed material, registration mechanics and public relations programs provided by MicroEnsure and AHN TZ.

Despite the significant changes made to the Imani Program between Phases 1 and 2, the results in two critical areas were substantially the same.

1. Claims – The claims experience for the program through July 31, 2011 showed a loss to premium ratio of approximately 200% compared to the design loss ratio of 70%. Details of the claims incurred are provided in Attachment 4. The most important exhibit in this attachment is the sheet which summarizes numbers of claims and cost of claims for families and students combined. Outpatient malaria treatment was the driving force in both categories, and reflects the following:
 - a. The prevalence of malaria in the region

- b. The fact that many consider any fever related condition to be malaria
- c. The tendency of service providers to diagnose a variety of conditions as malaria so that Imani would provide coverage

It is also important to note in Attachment 4 the relatively small number of maternity claims incurred. As previously mentioned, some have suggested this artificially low number was the result of individuals waiting until a child was born to secure coverage, given the policy’s limits of five members per family.

In any case the loss to premium ratio is unacceptably high, and a continuation of the program would have to include measures to reduce this ratio.

2. Registration – despite the changes made in Phase 2 to give the local parishes ownership of the program, the number of families registering for Imani actually declined in comparison with Phase 1. A summary of registrations for the period including both phases is provided below:

	<u>Phase 1</u>	<u>Phase 2</u>	<u>Total</u>
Families registered	196	36	232
Students registered	198	0	198
Families renewing after Phase 1	45	0	45
Families not renewing after Phase 1	91	0	91
Total lives covered at Phase end	1,178	903	

As mentioned in Part IV, Marketing and Sales, Item #8, AHN and MicroEnsure had hoped to secure between 750 and 1,200 (3,750 and 6,000 lives) family registrations during Phase 1 of the Imani program. Thus the above totals represented a significant disappointment.

VI. Preliminary Conclusions

Given that both the sales results produced and the cost to premium ratio were substantially adverse to the projected results, it is logical to draw at least preliminary conclusions from the experiences of the Imani pilot that can be applied to future faith based micro health insurance programs that may be undertaken. The following, in no priority order, are such conclusions:

1. The decision to simplify Imani by creating a product that covered only four specific medical conditions resulted in unexpected confusion among both covered patients and service providers. A policy covering all medical conditions for in-patient, out-patient or both may be more practical.
2. Because the concept of micro health insurance is still relatively new in developing countries, intense communication and education is required that will necessitate full time professionals responsible for these activities in the early stages.
3. The perception, by potential participants, of the quality of the service providers in the network is important in the buy decision. Thus a workable program must include either/or the majority of desirable providers in the community or an education program to explain the quality of providers in the network.
4. A MHI program exclusively designed for the poor will generate very limited revenue for marketing, sales incentives and start up costs. Thus, such a limited program will almost certainly require subsidies either to the program providers, the premium payers or both.
5. A program that only meets the affordability criteria of the poor, may well not meet the health requirements of a broader audience. Thus a program that targets substantial market penetration may well require multiple premium/benefit options to appeal to a broader audience.
6. The question of whether an urban or rural setting is best suited to MHI is still open. The former provides more service providers and a denser patient population. The latter provides an opportunity to build a program around a targeted service provider that can assist in the marketing of the program.

- 7. A faith based entity that desires to act as a marketing and sales channel for a MHI program must overcome the inherent limitations of poor infrastructure, limited communication and broadband facilities and limited educated personnel with time to participate in these efforts on a voluntary basis.**