

## Annex 2: Examples of Successful Business Models in Risk Pooling Arrangements

As described in detail in Section II, risk pooling arrangements in Sub-Saharan Africa can be found in discrete regional and population niches. Private schemes are predominantly found among the wealthy, foreigners, and/or employees of large corporations. For example, in Namibia and Zimbabwe—two of the more developed insurance markets—private insurance accounts for 20–30 percent of health care expenditure even though it covers only three to seven percent of the population. An additional core of risk pooling arrangements is concentrated in employer-managed health plans, which are increasingly common even among small enterprises. Employers outsourcing the administration of their medical plans to separate insurance companies and workplace clinics also represent an emerging trend in the development of health insurance and HMO industries in Sub-Saharan Africa.

In West and East Africa, community-based health insurance schemes (a term that includes a diverse array of risk pooling arrangements with varying degrees of sustainability) are widespread; as many as 600, with over 1.5 million beneficiaries, have been launched in Francophone Africa in the past 20 years.

Many countries have sought to implement social security systems, but success has been restricted by the limited size of the formally employed population. Micro health insurance, health savings accounts, or health credits all play a minimal role in Sub-Saharan African society, where low levels of social cohesion due to ethnic diversity undermine trust in the willingness of other groups to pay for future risks. Nevertheless, these mechanisms present long-term growth opportunities, especially given a considerable cultural shift toward pre-paid mechanisms.<sup>112</sup>

Figure A2.1 shows the large variability in the development of the health financing industry across three sample countries.

Although the market is nascent, some governments are starting to view private risk pooling arrangements as a potential mechanism to extend health care to the broader population. For example, Nigeria, the continent's most populous nation, has recently approved a compulsory national health insurance scheme to be implemented by private enterprises with the ultimate goal of extending coverage to the entire population. Also in Nigeria, bilateral donor funds are passing through a private HMO to subsidize basic health care insurance to 115,000 people in two poor target groups.

Overall, we estimate that risk pooling arrangements will represent about 13 percent of the projected cumulative investment demand in private health care, or about \$1.4–\$2.5 billion. About 80 percent of this is estimated to consist of investment opportunities below \$3 million (Figure A2.2).

### Focused Strategies Are Being Tested

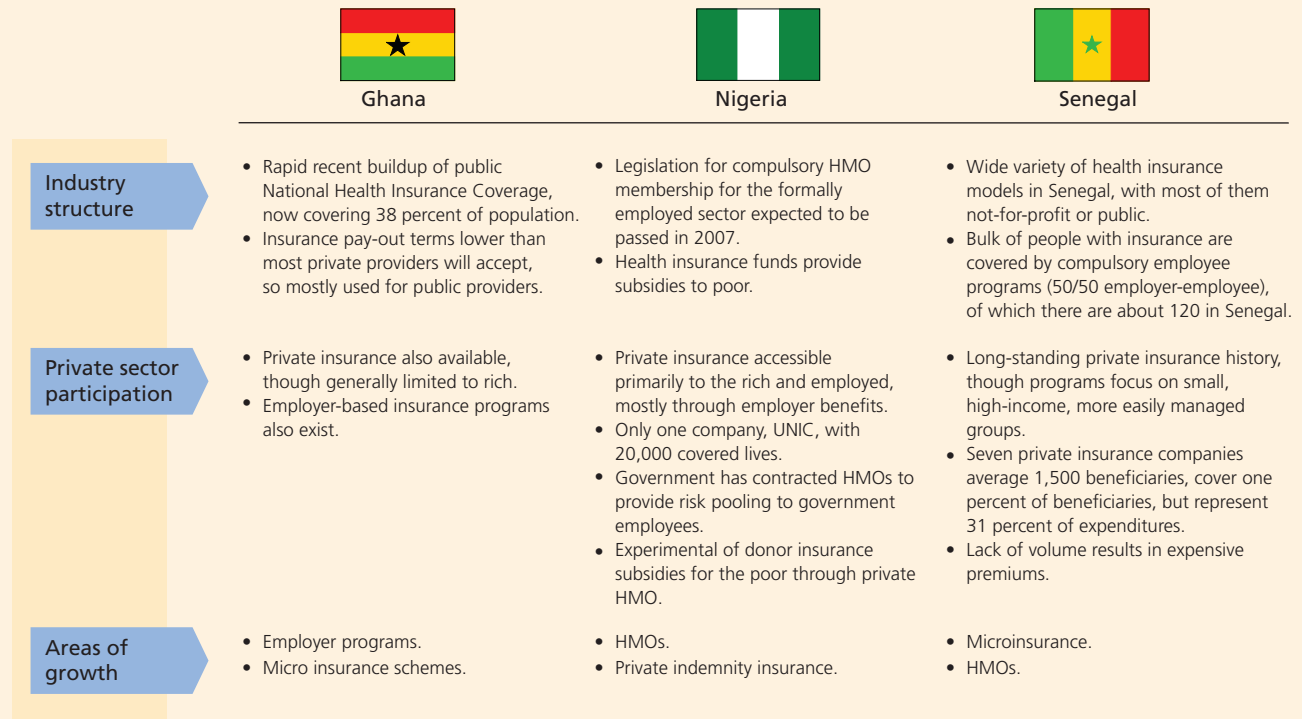
In these nascent markets, the challenge for new companies is twofold: how to reach minimum economic scale as fast as possible, and how to finance operations during the initial money-losing phase.

The following are some of the strategies that have been shown to work well; companies that adopt them can be attractive investment opportunities.

- **Access to large and randomly selected groups.** The size of the population pool is key. A risk pooling scheme requires a minimum of 20,000 people. With this size, unsystematic risk can be diversified within the insured population as a

Figure A2.1

### Risk pooling arrangements in selected countries



Source: Ministries of Health; country interviews; McKinsey analysis.

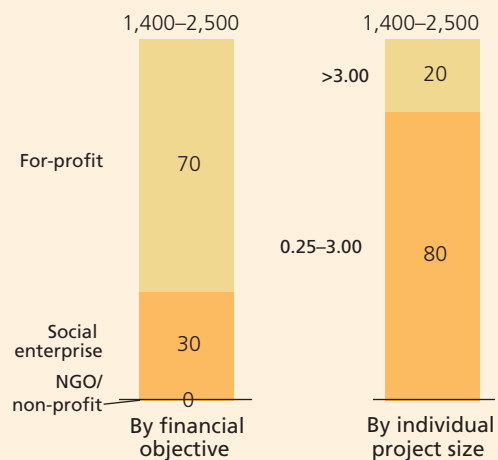
whole so that it is not necessary for every product to be profitable in order for the overall plan to be viable. With more than 100,000 lives, a scheme can optimize individual risk pools for each plan, making each product profitable on its own, or it can offer more extensive coverage, covering, for example, chronic diseases, as well as products for higher-risk groups. An additional condition for the success of this strategy is that the population must be randomly selected in order to avoid the adverse selection issues that a voluntary scheme naturally incurs. Given the size and nature of the populations composing public workforces, outsourcing agreements with governments that cover a group of employees are a natural opportunity for programs of these kinds.

- **Vertical integration.** Integrating the risk pooling mechanism with service provision significantly increases the likelihood of financial viability, since the possibility of fraud is reduced

Figure A2.2

### Risk pooling investment opportunity, cumulative 2007–2016

Percent, \$ million



Source: Ministries of Health; National Health Accounts; country interviews; McKinsey analysis.

and direct access to data on the covered lives allows for optimization of each plan.

### Several Successful Business Models

Figure A2.3 illustrates selected examples of business models that effectively leverage the strategies discussed above; these models can help business to achieve financial success while also having significant development impact.

A detailed description of these models follows.

#### Indemnity Insurance as Part of General Insurance

Indemnity insurance is a classic fee-for-service insurance model that generally targets the employed segment of the population. Several large general insurers in the region are considering extending their service lines to include indemnity health insurance. This model would charge a fixed fee premium based on subscriber's risk profile and could be available for groups or individuals.

Given the large customer base that most of these insurance companies already have, offering

an indemnity health insurance product would be a natural product line extension. The extensive databases these payers maintain regarding their customers—including which products they purchased and their creditworthiness—means that cross-selling can be tailored and focused. The life insurance information contained within these databases can be used to price premiums. In fact, several organizations have already started offering indemnity insurance across Sub-Saharan Africa.

Investments in this sector could fund capital expenditures in new equipment, skill enhancement, and marketing efforts. Some investments could also fund acquisitions of the indemnity arms of other companies. In the Sub-Saharan African context, opportunities in this area typically have a revenue basis of \$1–\$5 million.

The key drivers of profitability are operational scale and insured population demographic make-up. Most companies aspire to make the bulk of their profits on investment earnings from premiums while only breaking even on medical costs. Kenya and Tanzania have seen the growth of organizations using this model over the last few years.

Figure A2.3

### Promising investment themes in risk pooling arrangements

	Examples	Annual revenues \$ million	Setup cost \$ million	Development impact
Indemnity insurance within general insurance	<ul style="list-style-type: none"> <li>Strategis (Tanzania), UNIC Health (Nigeria), GLICO (Ghana), CFC Life (Kenya), The Cooperative Insurance—CIC (Uganda).</li> </ul>	<ul style="list-style-type: none"> <li>1.0–5.0</li> </ul>	<ul style="list-style-type: none"> <li>2.0–4.0</li> </ul>	<ul style="list-style-type: none"> <li>Creates an insurance culture.</li> <li>If properly scaled and managed, can force efficiency gains within the network of service providers.</li> </ul>
HMOs integrated with service providers	<ul style="list-style-type: none"> <li>Hygeia (Nigeria).</li> <li>Total Health Trust (Nigeria).</li> </ul>	<ul style="list-style-type: none"> <li>0.5–15.0</li> </ul>	<ul style="list-style-type: none"> <li>1.5–7.0</li> </ul>	<ul style="list-style-type: none"> <li>Increases accessibility to health care services to broader population.</li> <li>Risk pool sharing makes health care more affordable.</li> <li>Acts as a catalyst in building a provider network of both private and public clinics.</li> </ul>
Micro health insurance associated with microfinance institutions	<ul style="list-style-type: none"> <li>N/A in Sub-Saharan Africa.</li> <li>Application potential for Grameen Kaylan (Bangladesh) model.</li> </ul>	<ul style="list-style-type: none"> <li>0.5–5.0</li> </ul>	<ul style="list-style-type: none"> <li>1.0–2.0</li> </ul>	<ul style="list-style-type: none"> <li>Provides financial protection for low-income groups.</li> <li>Establishes an insurance culture across rural and underprivileged segments.</li> <li>Catalyst for growth of providers within these segments.</li> </ul>

Source: Country interviews; McKinsey analysis.

Life insurance companies, specifically, have broadened their product portfolio by offering indemnity coverage. Uganda is also well positioned to see this model flourish given the relatively large number of general insurance companies there. Conversely, countries with established national health insurance schemes (like Namibia, Nigeria, Senegal, and Zimbabwe) may not be favorable markets for this business model.

Figure A2.4 shows the key features of this business model and the financials for private insurance in Tanzania.

### Integrated HMOs

Several health insurers are starting to offer a range of medical services themselves. These models provide broad insurance coverage with restricted provider choice. This usually involves a capitation model or in-house provision for care. By providing in-house health services (generally primary care), insurers can more efficiently control claims cost and fraud. Furthermore, additional availability of information can allow rigorous case management.

The market for these financing vehicles is growing significantly, although setbacks have occurred

Figure A2.4

### Case study, private insurance: Strategis, Tanzania

Tanzania's leading private insurer, Strategis has experienced rapid growth from corporate subscribers, and has set aggressive growth targets for underwriting large insurance funds, more local companies, and individuals.

#### Tanzania's leading private insurer...

- Strategis offered the first private health insurance in Tanzania. It designs, underwrites, and sells medical insurance to:
  - Companies
  - Affinity groups
  - Families and individuals
  - Travel cover (in/out)
- Three percent profit before tax, almost exclusively from underwriting given limited investment income opportunities.
  - Currently > 90 percent corporate, plan to increase retail to 30 percent.
- Network of > 100 contracted private providers throughout the country.
- Quality standards part of provider contract, but hard to enforce if no alternative provider is available.
- Expatriate management provided through AMSCO project (funded by UN and IFC).
- 30,000 of Tanzania's 60,000–70,000 insured lives.

#### ... Strategis has experienced rapid growth from corporate subscribers...

- Four year old company with 2005–2006 subscriber growth of ~50 percent.
- Past growth driven by corporate accounts (first multinational corporations, then local companies).

#### ...and has set aggressive growth targets for underwriting large insurance funds, medium sized enterprises and individuals.

- Growth targets of doubling underwriting in 2007 and 50 percent growth in 2008.
- Strategis has tendered for new Dutch Health Insurance Fund contract to insure large, generally non-wealthy population.
- Corporate insurance continues to offer near term growth with good margins.
- Retail growth opportunity in medium-term, given growth in employed families seeking quality care.
  - Currently <ten percent retail, with 30 percent target
  - First local company with individual risk assessment capability for retail underwriting. Able to partner with affinity groups and banks for retail volume.
- Key growth challenges include:
  - Competition from new entrants for both subscribers and personnel.
  - Uncertain regulatory environment: New legislation expected on HMOs may have consequences for registered insurers.
  - Uncertain impact of National Health Insurance Fund's aspiration of growing coverage to 45 percent of Tanzanian lives by 2015.

Source: Country interviews; McKinsey analysis.

in some East African countries. In countries with compulsory schemes or tax incentives, this industry is projected to grow. The model is relatively well-developed in Namibia, Nigeria, and Zimbabwe. Other countries have smaller enterprises but are looking to expand. So far, individual HMOs have not been able to grow their revenues over \$15 million in Africa.

Health insurance usually operates with high loss ratios and low reserves; however, with limited investment income opportunities, a profit margin needs to be generated through underwriting. Containment of medical costs within a member population is an important key to profitability. The recent failures of some HMOs in Kenya that lacked in-house care provision indicate that vertically integrating primary care may be a critical element

of success. The prevalence of vertical integration financing opportunity could be higher in countries like Namibia and Zimbabwe, where several large HMOs are already active.

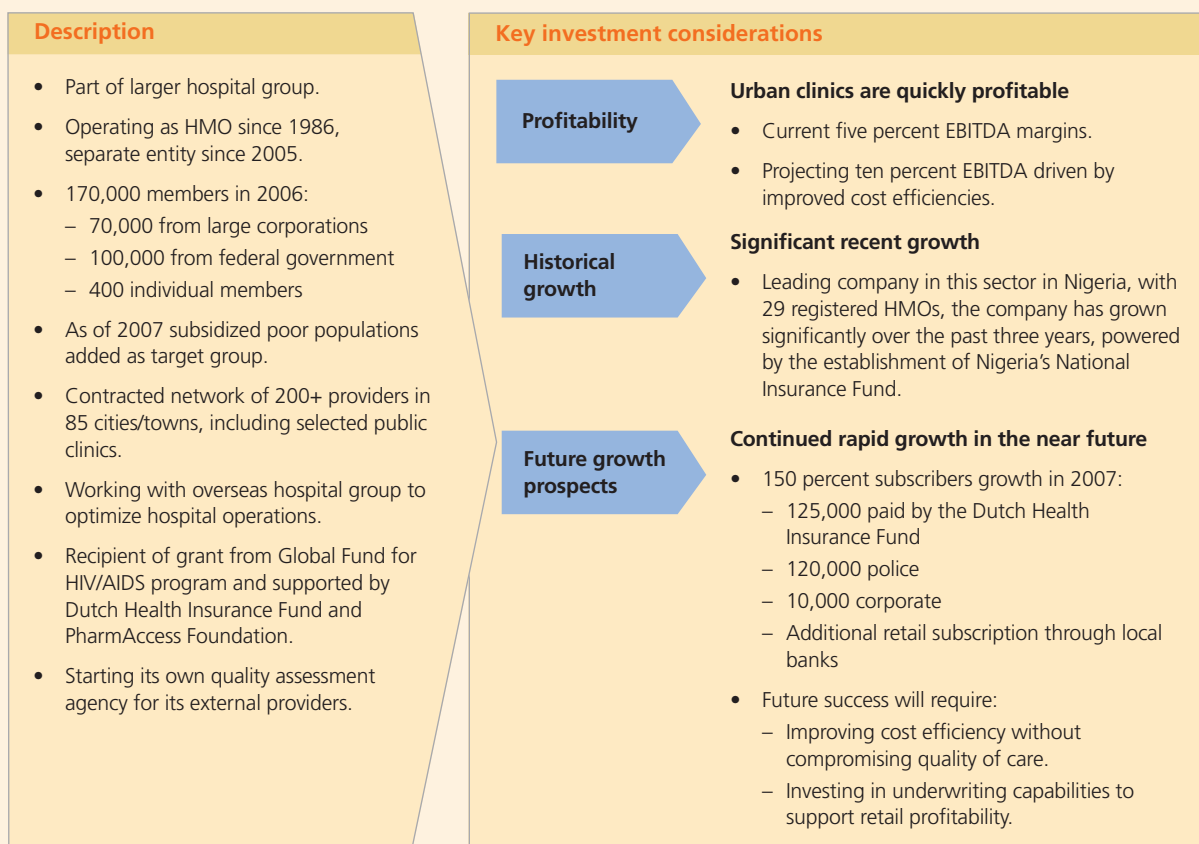
Although cost containment through in-house managed care can make insurance affordable, the main development impact is the creation of incentives to catalyze the creation of a larger provider network. Integrated HMOs are also central to establishing an insurance culture across the region.

Figure A2.5 shows the key features of this business model and the financials for such an integrated HMO in Nigeria. While this initiative is still not making a profit, it is expected to rapidly achieve break-even status followed by sustained profitability once subscriptions peak.

Figure A2.5

### Case study, integrated HMO: Nigeria

Large Nigerian HMO with more than 170,000 members and over 200 providers, the company is in the midst of a growth phase.



Source: Country interviews; McKinsey analysis.

### Micro Health Insurance

Microinsurance remains rare across Sub-Saharan Africa, but creating incentives for customers to buy health insurance along with traditional microfinance products could create an excellent opportunity to spur the growth of the market and extend health care coverage within the poorer segments of society and rural populations.

Plans including basic coverage for common or catastrophic conditions would be sold by the microfinance corporation and would be linked to products like loans. Combining insurance products and loans could yield cost synergies by reducing the transaction costs of separately offering loan and insurance products.

In Sub-Saharan Africa, the expected scale for such vehicles is \$0.5–\$5 million. Profitability is tightly linked to administration costs and default rates; these can be significantly reduced if linked

to other microfinance products such as loans. In addition, products with higher cost sharing with customers can further increase margins.

Most examples of microinsurance available today involve social enterprises that are ready to accept sub-commercial rates of return on their businesses. In Bangladesh, where such models are significantly more developed, micro health insurance achieves up to 39 percent profit (Figure A2.6). This model must be built on the existing infrastructure of a microfinance institution to amortize enrollment and premium collection costs. Extending customer reach through financing pools such as farmers' associations is critical to the success of these models.

Given the aggravated financial risk of insolvency that could be brought on by an epidemic, the need to subsidize catastrophic coverage is acute within this sector. Governmental and donor sup-

Figure A2.6

#### Case study, microinsurance: Grameen Kaylan, Bangladesh

Grameen Kaylan is a micro health insurance scheme created by the Grameen Bank, recipient of the 2006 Nobel Peace Prize. It offers pre-paid insurance to all Grameen Bank employees and borrowers, as well as the poor close to any of its clinics.

##### Grameen Kaylan offers pre-paid insurance for the poor...

- Health program initiated in 1993.
- Ten clinics and \$40 million endowment fund for start-up of operations.
- Upgrade of facilities and expansion financed by grants from International Labor Organization.
- Six health centers financed by donations from Stitching.
- Out of 2.5 million microfinance clients, 58,000 subscribe to voluntary health insurance.
- Pre-paid insurance card valid for 12 months.
- Insurance coverage includes:
  - Free check-ups
  - Pregnancy cost
  - Limited hospitalization
  - Discounts for drugs and diagnostic services
- Network of about 50 doctors in 29 rural health centers.
- Providers available for non-members who pay more.

##### ...in a financially successful model

###### Sample financials 2004

###### Income statement

###### Revenues

- No. covered lives 290,000
- Revenue \$ 338,005

###### Costs

- Claims \$ 5,164
- Administration \$ 38,611
- Commissions \$ 163,687

###### Operating income

- Depreciation Non notable
- Taxes Non notable

**Operating margin 39%\***

\* Excluding grant funding of additional \$126,015.

Source: NGO website; country interviews; McKinsey analysis.

port would be essential to manage and subsidize this risk. Microinsurance products provide a significant level of financial protection for low-income groups. Furthermore, they establish a platform for more evolved health care products across communities. This, in turn, stimulates demand among the poor and acts as a catalyst for overall growth of provision in this segment.