LESSONS LEARNED
AND GOOD PRACTICES
IN HEALTH
MICROINSURANCE

A guide for practitioners

By Taara Chandani and Denis Garand
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### ACRONYMS

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<tr>
<td>ADA</td>
<td>Appui au Développement</td>
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<td>AKAM</td>
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<td>BMZ</td>
<td>German Federal Ministry for Economic Cooperation and Development</td>
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<td>CARD MRI</td>
<td>Center for Agricultural and Rural Development Mutually Reinforcing Institutions</td>
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<td>CBHI</td>
<td>Community-based Health Insurance</td>
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<td>CERMES</td>
<td>Centre de Recherche Médecine, Sciences, Santé et Société</td>
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<td>CHAT</td>
<td>Choosing Health Plans Together</td>
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<tr>
<td>CIDR</td>
<td>Centre International de Développement et de Recherche</td>
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<td>COHSASA</td>
<td>Council for Health Service Accreditation of Southern Africa</td>
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<td>FFH</td>
<td>Freedom from Hunger</td>
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<td>PACE</td>
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<td>Strategies and Tools against Social Exclusion and Poverty</td>
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<td>UMSGF</td>
<td>L’Union des Mutuelles de Santé de Guinée Forestière</td>
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<td>VAS</td>
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INTRODUCTION

Purpose of this guide

Although microinsurance is relatively new, it is gathering momentum and additional resources are clearing the pathway for product and service innovations. Over the last decade, health microinsurance (HMI) in particular, has evolved as a result of experimentation in the use of products, partnerships, technology and delivery.

This guide takes stock of the learning in HMI to date and offers practical advice to implementers and knowledge practitioners.

Specifically, it aims to support implementers of HMI programs to design and administer client-centered, viable schemes by:

- Presenting lessons that have been generated from experiences across contexts and by different actors, focused primarily on non-state actors.
- Offering practical how-to advice for those involved in HMI or interested in becoming involved in delivering HMI services.
- Flagging key unanswered questions that have arisen in the course of operations and research.

Box 1

Health Microinsurance Products and Emerging Lessons Inventory

The objective of the searchable Health Microinsurance Products and Emerging Lessons Inventory is to catalogue all known active and non-active private sector health microinsurance products, as well as community based and social insurance schemes.

Lessons based on the experiences of these health microinsurance schemes can serve as a guide to overcome many of the challenges that limit the growth and impact of the sector.

Types of Inventories:

- The Health Microinsurance Products Inventory is a repository of more than 100 active and non-active health insurance products offered to low-income persons in low- and middle-income countries by commercial insurers, community organisations, governments, microfinance institutions, mutuals and non-governmental organisations, among others. The inventory provides detailed information on the design, administration and delivery of health insurance products and services.

- The Health Microinsurance Emerging Lessons Inventory includes lessons extracted from academic journals, publications by members of the Network and partner organisations, and submissions from practitioners and other stakeholders actively working in health microinsurance and health systems innovation.

All health insurance schemes featured in the inventory are inclusive of low-income households.
This guide has been commissioned by the Microinsurance Network and its Health Working Group, the exchange platform for donors, non-government organisations (NGOs), and the insurance industry in the area of insurance for the poor.

In 2012, the Health Working Group of the Microinsurance Network launched an inventory project of HMI products and lessons learned. This inventory project captured emerging trends and lessons from more than 100 HMI schemes in over 40 developing countries. A majority of the sources of these lessons are thematic self-evaluations and action-based research conducted by HMI schemes. Approximately 75 of the active schemes are in Asia, followed by over 50 in Africa and nearly 20 in Latin America.

This guide also references other research supported by the Microinsurance Innovation Facility, the Microinsurance Learning and Knowledge Project (MILK), the ILO’s Strategies and Tools against Social Exclusion and Poverty (STEP) program, and others. The authors also interviewed a handful of HMI implementers to fill gaps in the literature and gain insight on particular innovations.

**Definitions and scope**

Health microinsurance is different from other types of insurance in several key ways and therefore specific considerations apply:

- **At its core, health insurance is about financial protection and health service delivery.** Some HMI schemes tend to focus on the former, offering financial protection from catastrophic illness, while others aim to improve health outcomes and emphasise a broader “medical care” model.

- **The medical provider in HMI schemes, in many respects, is the product.** Involvement of health care providers adds complexity and costs related to moral hazard and fraud, as well as monitoring of medical service quality.

- **On the demand side, clients are extremely sensitive to benefits, costs, and how health services are rendered**—so generating demand is not easy. This is compounded by poor “insurance literacy” and mistrust.

- HMI models are extremely varied in their public and private mix, coverage of benefits, target market, and institutional priorities—often making it difficult to compare programs or transfer best practices that may only work in a given context.

- The changing disease burdens and exposure to health risks, and limited availability of morbidity data in developing countries, particularly for low-income population segments, make product design a challenge.

- The availability of health insurance can potentially change behavior (by inducing greater utilisation of health care) and morbidity patterns (by preventing deaths), thus requiring adequate and up-to-date medical data.

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1. To visit the Microinsurance Network Health Working Group Health Insurance Products and Lessons Learned Inventory and view a video explaining how to use the inventory, see http://microinsurancenetwork.org/working-group/Health/7.php.
Box 2

What is health microinsurance (HMI), and how is it delivered?

HMI is broadly defined as the provision of health insurance for the low-income market. Most HMI schemes are managed according to basic insurance principles; HMI protects those with cover against specific health risks in exchange for regular premium payments, proportionate to the likelihood and cost of the risk involved.

HMI schemes encompass a wide variety of models, including:

- **Community-based health insurance (CBHIs)**, also known as mutual health organisations, which are not-for-profit associations based on member solidarity and participation that typically are governed by non-insurance regulations.

- **Partner-agent schemes** that are set up by risk carriers (e.g., commercial insurance companies or NGOs) in partnership with delivery channels (e.g., microfinance institutions or cooperatives). They may also involve third-party administrators (TPAs).

- **Health-provider managed insurance schemes**, in which a health center or a hospital offers users a reduction in health expenses, typically for a defined package of services, in exchange for the payment of a premium.

- **Social health insurance programs** that are conceived and funded by governments (through general or payroll taxes), sometimes in partnership with private insurers, administrators and non-state delivery channels (such as community groups or cooperatives).

The case for HMI and where we stand today

A majority of the world’s poor have limited access to adequate health care, with potentially devastating results on their health and well-being. The poor often cite financial barriers as reasons for delaying or deferring seeking health care. When care is sought, the associated expenditures pose a large burden on households and can trigger a spiral into poverty. Aggregate data from across the globe magnifies this point: around 150 million people each year face financial catastrophe, and 100 million suffer impoverishment simply because they need to pay for health services. More than 90 percent of these people live in low-income countries (Xu et al, 2007).

HMI holds great promise in expanding access to health protection for the poor. Developing countries account for as much as 90 percent of the global disease burden, but only 12 percent of all health spending (World Bank, 2006).

Given the resource constraints by governments to scale-up national health programs or achieve universal coverage, the case for private and hybrid public-private models to help fill the gaps is increasingly clear (Leatherman et al, 2012).

The HMI sector has experienced substantial innovation to date, leading to a more nuanced understanding of what works best for a given context and target market. The drivers for client enrollment are becoming clearer, though evidence is still needed on what retains clients in schemes and how insurance actually affects...
patterns of health care use. The case for covering outpatient care and including value-added services (VAS) is becoming stronger, as a greater number of schemes experiment with delivering such health care in ways that appeal to clients and support their bottom line.

Different models for engaging with providers are emerging, with many showing promise in utilising alternate health cadres that are more appropriate for communities and can act as gatekeepers. Technology is increasingly at the frontline in bringing down costs and improving service coverage and quality. While these and other practices are starting to reap benefits in terms of institutional sustainability, many HMI schemes continue to struggle to deliver comprehensive benefits at a price point that works for low-income communities.

This guide presents key lessons that have emerged in these and other areas, and highlights questions that deserve ongoing attention and experimentation.
Using this guide

The guide is framed according to four lenses that encompass the gamut of operations for health microinsurance schemes: reaching poor households, expanding product benefits, delivering quality medical services, and achieving institutional sustainability. Two of the components, expanding product benefits and delivering quality medical services, represent two sides of enhancing client-value.

The four components are closely interrelated and dynamic. For example, institutional sustainability is inherently tied to a program’s ability to deliver quality medical services and ensure high client enrollment and retention; likewise, technology can impact across a scheme, enhancing the delivery of medical care and reducing operational cost structures. Implementers should review the four components through a dynamic lens rather than treat them as stand-alone blocks. As such, the connections between different operational elements, including product design, quality of care, client retention, and sustainability, will become apparent.

Many of the lessons and how-to steps are based on experience and experimentation rather than scientific evidence. As the field continues to grow and change, so will this base of knowledge. This guide aims to be comprehensive in presenting lessons across the range of HMI operations but is limited in the evidence available, yet it flags open questions and areas for further investigation and testing. It also offers several practical manuals that practitioners can refer to for detailed guidance in a specific technical area. Finally, this guide synthesises lessons from different contexts and types of programs. While it has tried to draw lessons that are applicable to a broad base of models, some advice may only be relevant in certain contexts and for particular types of programs.

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2 While HMI has been the focus of a greater number of evaluations compared with other microinsurance sectors, the studies tend to be limited in the type of questions they address.
1. REACHING POOR HOUSEHOLDS

This chapter will lay the foundation for how HMI schemes should:

- Assess client demand
- Identify the right distribution channels to reach prospective clients
- Educate clients about insurance and promote the product
- Introduce appropriate enrollment features

Understanding need and demand for health insurance

Insurance can increase utilisation of health services, especially among the poorest, and potentially improve the quality of care they access.

Evidence from across continents supports the premise that with insurance, poor people are more likely to utilise health care and reduce out-of-pocket payments relative to the uninsured (Chee et al, 2002; Hatt et al, 2009, McGuinness & Mandel, 2011). In some cases, this increased access to health care is highest among the poorest groups (Lepine & Le Nestour, 2011), indicating a progressive distribution of benefits. Early evidence also suggests a link between enrollment in HMI schemes and access to better quality medical care, which is discussed in greater detail in Section 4.

What is less clear is how greater access to health care affects behaviors, whether and how it induces over-utilisation of services, and/or improves health outcomes over time. In Nicaragua, a study conducted in 2009 showed that improving access to providers likely improved efficiencies in how care was used by the family. For example, insured children were more likely to access health care relative to the uninsured only when children were actually reported as being sick at the baseline; interestingly, when children were not sick, the uninsured were more likely to report seeking care than the insured. Thus, insurance seems to have led to more effective decision making among insured families on when to seek care (Fitzpatrick et al, 2011).

OPEN QUESTION

How does health insurance affect patterns of health care utilisation and morbidity and long-term health outcomes for households and communities?

There is high “need” for health microinsurance, but it does not consistently translate into demand.

Across contexts, low-income groups often cite financial barriers as reasons for delaying or deferring seeking health care. When care is sought, the associated expenditures pose a large burden on households and can trigger a spiral into poverty. Despite the potential of HMI to protect the poor from catastrophic health
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events, reduce out-of-pocket health expenditures and improve access to health care (Leatherman et al, 2012), its uptake is still low among vast segments of the poor.

Evidence provides a variety of reasons to help explain why clients who “need” insurance may not actually purchase it (McCord et al, 2011, Dalal et al, 2012, Khan, 2012). Listed below are the reasons to keep in mind:

- Affordability of the product and alignment of payment schedules with income streams
- Scope of coverage, and whether it includes benefits that are perceived as most important, or cover the most expensive or frequent health events
- Availability of other coping mechanisms, such as savings or loans
- Understanding of insurance and trust that valid claims will be reimbursed in a timely manner
- Social pressures or beliefs around prepaying for a potential adversity

While many of these reasons apply across geographies, some may be more salient in a given context.

Further evidence around these drivers, and the extent to which they affect uptake, are discussed under consumer education in this Section, scope of coverage and pricing products in Section 2.

A key takeaway for HMI schemes is to carefully test how simple changes in marketing efforts, consumer education, and product coverage resonate with clients.

Distribution partners can be an important bridge to address issues related to poor demand, including lack of trust, low awareness, dissatisfaction with the coverage and price, and geographic access.

Box 3

What type of coverage do clients want?

An increasingly common reason that is cited for low-enrollment among HMI schemes is the limited availability of outpatient care (Pott & Holtz, 2013). Clients have a low perceived value for hospitalisation products, which are the most widely available but which fewer than five percent of clients typically claim (Leatherman et al, 2012). Recent longitudinal research from India shows that low-income households are three times more likely to fall into poverty in a given year as a result of outpatient expenditures than they are from hospitalisation episodes (Berman et al, 2010), and other estimates show that outpatient expenses are ten times more onerous for poor households than inpatient expenses over a ten-year time frame (Pott & Holtz, 2013).

While catastrophic health events can quickly impoverish a family, there are indications that households are more successful in drawing on support from family and friends for these infrequent events (Pott & Holtz, 2013). Moreover, recent studies show that non-medical or “indirect” costs associated with hospitalisation, such as transportation expenses and lost income, comprise a significant uncovered expenditure; in one study, insurance covered only 25 percent of the total costs incurred by the insured (Magnoni et al, 2012) and may explain part of the “demand” question.
Identifying the right distribution partners

Engagement with preexisting groups that instill trust is showing promise in health microinsurance.

A variety of distribution models can be used to deliver health insurance to low-income clients: microfinance institutions, farming or trade cooperatives, CBHIs, NGOs, employers, as well as government agencies. Though less common, insurance companies can also directly distribute insurance. As in the delivery of any microinsurance product, delivery channels are important to reach scale, offer efficiency in managing transactions, and ultimately, keep costs down. Effective channels are typically involved in regular financial transactions with their members (such as trading cooperatives or MFIs) and can leverage systems for premium collection and claims payments.

In HMI, evidence from practitioners suggests that engagement with groups in which members have interpersonal relationships, such as NGOs, savings groups, or cooperatives, are more appropriate for the delivery of HMI than anonymous, transaction-driven networks, such as telecom companies (Naya Jeevan Pakistan, Learning Journey; l’Union des Mutuelles de Santé de Guinée Forestière – UMSGF, Guinea, Learning Journey; interview with MicroEnsure). Because clients are extremely sensitive to HMI product features, including benefits and exclusions, and typically have little understanding of how HMI works or where to access care, greater engagement and experience-sharing is important. Across geographies, HMI schemes have seen that experience-sharing between clients and with prospective clientele result in higher ownership, trust, and uptake (e.g., Uplift Mutual India, VimoSEWA India, Swayam Shikshan Prayog - SSP India, Naya Jeevan, Centre de recherche médecine, sciences, santé et société - CERMES, Mali).

Many HMI schemes are voluntary in design, so engaging with preexisting groups is a first step to mitigating adverse selection. In addition, some schemes may introduce features such as compulsory family enrollment or waiting periods (discussed further in Section 4). Some HMI schemes that partner with MFIs, such as Uplift Mutual in India, have successfully made their products mandatory for all borrowers and have priced them low enough to avoid dropping out from the MFI. Uplift Mutual also introduces

Box 4

Microfinance institutions (MFIs) as delivery channels for health insurance

MFIs are common distribution channels for health insurance. They promise access to large numbers of low-income people, particularly women, act as a platform to frequently collect premiums, and serve as a channel to deliver health education and referrals for health services. Research by Freedom from Hunger showed that when MFIs integrated health education with financial services (including insurance), there was improvement in preventive health behaviors, such as hand washing, and greater geographic and financial access to health providers (Metcalf et al, 2012). On the flip side, there is evidence of resistance among clients to enroll in health schemes through an MFI if they are not already a borrower. In Nicaragua, where the National Social Security Institute (INSS) partnered with MFIs, clients raised doubts about the expertise of MFIs in dealing with health-related issues, and expressed suspicion that the MFIs would try to profit from the arrangement (Hatt et al, 2009).
low-cost, VAS in the form of preventive health talks for clients and a 24/7 telephone hotline, which has increased client retention (Pott & Holtz, 2013). In Guinea, UMSGF has instituted a mandatory health insurance product at the village level and learned that it is important to obtain a realistic population census prior to the promotion of a product to assist with enrollment projections (UMSGF Learning Journey).

Distribution channels should have a vested interest in “pushing” the insurance product, including providing information and education. Ideally, distribution channels should benefit from engaging in a HMI partnership and take an active role in “pushing” an insurance product. For example, MFIs commonly introduce health insurance to meet a need that is expressed by low-income borrowers, thus potentially increasing their clientele and retention. This was one of the driving factors for the Center for Agricultural and Rural Development Mutually Reinforcing Institutions (CARD MRI) in the Philippines to offer health protection for their clients, leading to increased customer loyalty, retention, and positive health-seeking behavior (Metcalf et al, 2012; Reinsch & Metcalfe, 2010). Additionally, MFIs have a vested interest in protecting the health of their clients to ensure a strong loan repayment portfolio. Likewise, other channels such as employment cooperatives may hold an interest in making health insurance available to their constituents. In Pakistan, Naya Jeevan leverages corporate distribution networks to market and co-finance health insurance for low-income, informal workers across supply chains; it has met the corporate social responsibility objectives of these firms, as well as built loyalty among their staff (Naya Jeevan Learning Journey).

A channel can support an HMI scheme by actively marketing the product, educating clients about insurance, and potentially offering health information. The greater the alignment in objectives and capacity between all partners, the higher the likelihood of delivering a high-value product to clients.

Educating consumers and promoting the product

Consumer education is essential to increasing knowledge and use of HMI; it also has the potential to stimulate demand and alter health-seeking behavior. Consumer education in HMI carries three broad objectives: to stimulate demand and take-up of insurance, to increase knowledge and use of a particular product, and, to impact health-seeking behaviors. Its success is mixed across these layers.

While the case for consumer education to generate demand is intuitively strong, early evidence is inconclusive (Dror et al, 2011). It is generally accepted that insurance is sold, not bought. Prospective clients of microinsurance may hold deep convictions about insurance that need to be overcome, including cultural beliefs against insurance, mistrust of insurance companies, and lack of familiarity with risk pooling. Conversely, they may also have little or no knowledge about insurance. Recent research from Bangladesh supports the premise that education can increase knowledge about insurance and willingness to pay (Khan, 2012). Other studies present contrary findings: in Senegal, insurance literacy had no significant impact on take-up in mutual health organisations (MHOs), even when lack of knowledge was first cited by the uninsured as a barrier to joining (Bonan et al, 2012). Similarly, in Kenya, basic marketing and literacy training to tea farmers had no impact on utilisation (Dercon, 2012). In both cases, monetary discounts did have an impact on uptake, which is discussed in the following Section.
The case for consumer education to increase utilisation of a product after clients have enrolled in schemes is clearer. Practitioners recognise that insured clients may not utilise services, may be unsure of the benefits, or discontinue making premium payments while expecting to continue to receive services (Freedom from Hunger - FFH, Learning Journey). Low usage can quickly induce negative perceptions about a given product and threaten the viability of HMI schemes (SSP Learning Journey). Implementers across contexts observe that consumer education helps clients to recognise the value proposition in health insurance and builds their “know-how” and confidence in utilising a given product (e.g., SSP; FFH; Uplift). Education also leads to more effective use of the product, including visits to community health workers, outpatient clinics, and accredited hospitals (e.g., VimoSewa; Uplift; CARE).

A third promise of consumer education is to improve health-seeking behaviors, including prevention, and potentially improve prospects for HMI scheme viability by reducing the incidence of hospitalisation. The evidence is mixed on this point; however, it is also limited by the short-term nature of interventions and corresponding research. VimoSewa in India found that consumer education did not result in fewer hospitalisation episodes; however, it did improve preventive health practices (only in urban households and not rural). Behavior change campaigns can take multiple and sustained efforts to have an impact; for example, anti-smoking campaigns around the world have greatly benefited from mass media and targeted advertising as proven strategies (WHO Report on the Global Tobacco Epidemic, 2011).

**Consumer education should be simple, delivered over the long-term and integrated with product delivery.**

The precise design of consumer education will vary by context, available resources, and the underlying orientation of an HMI scheme. A comprehensive consumer education program can include an introduction to insurance or risk pooling, an overview of the product and how to access care, and finally, awareness on health issues and prevention.

Some programs may even go further to include household budgeting so clients appreciate their routine expenditures on health, understand how other coping strategies factor in, and are better able to manage small and large health risks (Dror & Matul 2012).

In practice, programs commit varying degrees of resources to consumer education and may address all areas with the same intensity. For example, MicroEnsure has developed three pillars in its consumer education modules that entail:

1. Using comic books, songs, and CDs to improve clients’ financial literacy enabling them to compare savings and insurance products.
2. Providing clients with an explanation of product benefits and logistics.
3. Educating the staff of an MFI or other delivery channel in the same issues, with an emphasis on claims administration (Dror & Matul, 2012).

Evidence from across countries shows that the most effective programs use participatory methods, integrate education with product delivery, and offer it on a continuous basis (Dror et al, 2012). Moreover, successful programs utilise a mix of channels, such as workshops or text messaging, as well as a mix of tools, such as interactive games and brochures. Exactly how HMI schemes allocate resources and design consumer education is case-specific: for example, MFI loan officers may discuss the HMI product during repayment interactions (individual or group); where transactions are managed through mobiles phones, HMI schemes can use text messages to remind clients when to renew coverage, or to visit a doctor for their annual check-up. All materials and delivery methods should take into account the existing knowledge of the population, language, culture, and customs.

In India, VimoSEWA observed that maintaining standardisation of health education sessions was a challenge. Thus, they developed guide-
## CONSUMER EDUCATION TOPICS AND TIPS

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<th>Illustration</th>
<th>Implementation tips</th>
</tr>
</thead>
</table>
| **Risk and insurance education** | - Introduction to risk management: What is a risk? How can risk affect you? How can you manage risk? What coping measures do you use?  
- Introduction to insurance: What is HMI? How does insurance differ from savings? What are premiums and claims? What are benefits and coverage limits? | - Provide data on the actual frequency of occurrence of insured health risks to make it more salient for clients.  
- Discuss the potential losses from not having insurance by encouraging sharing of life-experiences and coping behaviors of clients.  
- Encourage testimonials by clients who have used insurance services.  
- Avoid using complex terminology when introducing the concept of insurance. |
| **Product education**        | - Explain the scope of the HMI product including cost, benefits, limitations, and exclusions.  
- Review how to access medical services: the provider network, referrals, policyholder ID cards, and other documentation.  
- Instruct on filing a claim: claim requirements, initiating a claim, and expected waiting period.  
- Train on how to renew your policy: the fees, schedule, and considerations when your policy is up for renewal.  
- Explain partner roles and responsibilities: the insurer, delivery channel, third-party administrator, health facility, and client. | - Keep the product and information about the product simple.  
- Focus on how clients can benefit from insurance, rather than the terms and conditions of a policy.  
- Avoid over-promising access to services that may cause clients to utilise services they do not need.  
- Schedule education sessions at a time when clients have discretionary income.  
- Share information about product usage and encourage experience sharing between clients to keep conviction for the product high.  
- Send reminders for renewal through text messaging and discuss in person (e.g., during loan collection for MFI clients). |
| **Health education**         | - Health prevention, such as promoting preventive health and topical issues relevant for a particular context.  
- Health information and resources to include tips on accessing the health-care system, or linkages to non-covered health care. | - Provide clients with a list and map of network health-care providers.  
- Distribute materials with basics on health preventive behaviors for common issues.  
- Introduce telephone hotlines to respond rapidly to client questions.  
- Utilise tablets (such as iPads) or other interactive devices to educate clients, if costs allow. |
Lines to ensure consistency over time and across branches. These guidelines emphasised the need to focus on only one of three topics per session, on having members repeat key messages during sessions, and on conducting practical demonstrations on select health topics, including how to prepare oral rehydration salts (VimoSEWA Learning Journey).

Consumer education requires up-front planning, resource allocation, and reviews of cost-effectiveness.

Developing appropriate content for consumer education requires specialised insurance training and health knowledge. It may be necessary to hire experts to develop materials or advise on utilising technology solutions. HMI schemes should ideally integrate consumer education within the routine delivery of the product, but may also have to budget additional resources for this function, particularly at the early stages. Schemes should carefully evaluate the cost and benefit of these efforts to ensure that they are adding value. For example, SSP in India found that having a health advisor or head of a self-help group assist in education forums was necessary given their influential status in the community, despite the added costs (SSP Learning Journey).

Insurance schemes should measure the effect of consumer education on client awareness and knowledge, uptake, claims, renewals, as well as the cost-benefit of the service. Practitioners recommend combining qualitative feedback (discussions or surveys) with regular reviews of program indicators; it is also recommended that HMI schemes hire trained third-party evaluators to manage more rigorous studies of the impact of consumer education (FFH Learning Journey).

Open Questions

- What impact does consumer education have on the uptake of services, changes in client behavior, and morbidity over the long term?
- What are the most cost-effective forms of delivery for consumer education?
- Can technology replace participatory interactions, and under what circumstances?

Enrolling and retaining clients

Positive experiences and demonstration through claims have proven to increase client uptake and utilisation, and can potentially improve retention.

Endorsements from community members and peers, as well as successful experiences in claims settlements have been shown to be effective in encouraging prospective clients to enroll (e.g., SSP; Palmyrah Workers Development Society–PWDS, India; Calcutta kids India; National Social Security Institute–INSS, Nicaragua). In India’s national Rashtriya Swasthya Bima Yojana (RSBY) program, which offers inpatient cover for people below the poverty line, there is evidence showing that new enrollments were higher in districts where hospitalisation ratios were also high, indicating that word-of-mouth endorsements from early users encouraged others to join the scheme (Krishnaswamy & Ruchismita, 2011). Similarly, in Nicaragua, prior health status and usage of services among the insured led to higher retention (Fitzpatrick et al, 2011). Going a step further, research from Senegal hypothesises that the main determinants of renewal among clients is the positive or negative experience regarding utilisation, rather than simply whether a client visited a hospital or the price of the product (Dercon et al, 2012).

Despite these early findings, additional research is needed to explain what drives enrollment and retention in voluntary HMI schemes. The short tenure of many programs and unavailability of sufficient program data has limited this analysis to date.
Clients value simplicity and on-the-spot enrollment.

Across contexts, clients place a high value on quick and efficient enrollment. In Nicaragua, under a program lead by the National Social Security Institute (INSS), only 27 percent of clients signed up for the scheme after receiving a 6-month discount voucher when it entailed traveling to the MFI with photos and documentation. On the other hand, 68 percent joined when enrollment and photos were completed on-the-spot at their market stalls, even in the absence of any subsidy. “Time is money” to informal sector workers, who place a high value on streamlined enrollment and administration (Hatt et al, 2009).

In the RSBY scheme in India, there is also evidence of an increase in utilisation rates when cards are issued immediately and clients informed about how to claim. When operational delays occur, the likelihood of a policyholder making a claim decreases, while the risk that a card may not reach its intended beneficiary increases (Krishnaswamy & Ruchismita, 2011). Thus, verification-based smart cards used by the scheme have the increased advantage of authenticating clients and producing photo ID cards on-the-spot.

VAS show promise in improving enrollment and retention.

HMI schemes are increasingly introducing VAS to enhance the appeal of basic health insurance coverage, which is generally restricted to inpatient cover. They do so by adding a component of outpatient coverage, such as consultations or access to low-cost services or drugs (e.g., Aga Khan Agency for Microfinance-AKAM, Pakistan), or prevention services, such as health talks or health camps (e.g., Naya Jeevan). These services are tangible for clients, can sharply reduce their out-of-pocket expenses and may drive higher renewals. Many of these services utilise technology solutions, such as telephone hotlines to consult with doctors (e.g., Uplift), or remote diagnostic services for hard-to-reach communities (e.g., CARE Foundation), and can be offered at relatively low cost by HMI schemes (Pott & Holtz, 2013). Thus, by impacting retention, VAS can potentially support the viability of HMI schemes.

Family discounts are promising ways to increase uptake and encourage more members to enroll.

Incentives or discounts for clients to enroll full families show promise and help to avoid the exclusion of women and girls in situations where families value their female member’s health less than the health of males (Banthia et al, 2010). In India, VimoSewa offered an option for husbands and children to join at a lower incremental fee. The children’s coverage offered protection for all children under one premium to avoid families choosing which of their children to insure (Ibid). In some settings, compulsory registration of all family members has proven necessary to avoid exclusion, and mitigate selection, even where up to five members are eligible for enrollment (UMSGF Learning Journey; SSP Learning Journey).

Cross-subsidies between large and small families can help institutional viability. However, they may put a large burden on households if costs are incremental for each member. In Guinea, UMSGF learned quickly that large families could not afford the per-head premium for its mandatory safe motherhood product, so they offered a flat-rate premium instead. In other cases, including with AKAM in Pakistan, sliding scale discounts are introduced for children’s premiums, thus giving deeper discounts for each additional child and an incentive for larger families to enroll (McGuinness & Mandel 2010).

Time-bound premium subsidies may increase uptake but questions around their sustainability prevail.

Affordability remains a key barrier for insurance uptake, calling for strategies to cost-share, subsidise, or partner with the public sector to bridge financial gaps. Donors have started to experiment with phased subsidies
towards the premium, allowing the poor to experience health insurance and presumably increase their contributions over time.

Some efforts to increase enrollment through marketing incentives have worked in Kenya and Senegal (Dercon et al, 2012; Bonan et al, 2012). Other research suggests the retention rate is lower among clients who availed discounts during enrollment, compared to those who did not receive enrollment incentives (Fitzpatrick et al, 2011). This has important implications for product design, suggesting that those who are induced to enroll with subsidies place the lowest value on the insurance product and are less likely to continue payments (Ibid). Similarly, early experiences with PharmAccess and Hygeia in Nigeria indicate that it is a challenge to increase client payments once a subsidy has been in place for a certain period of time, particularly if the rate increases are significant. Having learned this, the Foundation has started to develop simpler, scaled back products in other countries - including Tanzania - that avoid the need for premium subsidies of over 60 percent (Interview with PharmAccess Foundation).

OPEN QUESTIONS
- What are the most successful strategies for enrolling and retaining large numbers of clients in voluntary HMI schemes?
- How do subsidies affect consumer behavior, including demand, and satisfaction for HMI services?
REACHING POOR HOUSEHOLDS SUMMARY

1. Need and demand

Insurance can increase utilisation of health services, especially among the poorest, and potentially improve the quality of care they access.

Need for health microinsurance does not consistently translate into demand.

Conduct research to understand the health-seeking and coping behavior of prospective clients: major health-care risks people face, sources of health care, perception of quality, and the cost of routine and catastrophic events.

Identify major barriers to enrolling in insurance: financial, geographic, cultural, trust, alternative options for care, etc.

Develop a plan to mitigate the barriers through consumer education, product design and/or partnerships.

Be prepared that the process to generate demand can be slow.

2. Distribution partners

Engagement with preexisting groups that instill trust is showing promise in HMI.

Channels should have a vested interest in “pushing” the product, including providing information and education.

Identify existing groups or associations that serve your target market.

Approach groups that have alignment in vision, the capacity to administer health insurance and ability to leverage financial transactions (e.g., collection of premiums).

Engage the distribution channel in decisions around HMI product packaging and dissemination to ensure ownership.

Align incentives so the channel actively promotes HMI.

Develop capacity of the channel to educate consumers and promote the product.

Channels should have a vested interest in “pushing” the product, including providing information and education.

Questions that deserve further investigation

- What are patterns of health care utilisation and morbidity among the insured, and how do these affect health outcomes for households over time?

- What is the impact of consumer education on take-up of insurance, changes in client behavior, and morbidity over the long term? What are the most cost-effective methods to deliver education, and to what extent can technology replace participatory interactions?

- What methods are most successful in enrolling and retaining large numbers of clients in voluntary schemes?

- How do subsidies affect consumer behavior, including demand and satisfaction for HMI services?
What we have learned

### 3. Educating consumers and promoting the product

Education is essential to increasing knowledge and use of HMI; it also has the potential to stimulate demand and alter health-seeking behavior.

Consumer education should be simple, long-term, and integrated with product delivery.

Consumer education requires up-front planning, dedication of resources, and partnership building.

- Develop a plan to incorporate consumer education with product delivery.
- Define “what” (content and tools) and “how” (who does it, how it is paid for).
- Start with a focus on risk management and insurance, then layer other topics as appropriate.
- Hire specialists in training, insurance, health, and other areas; seek low-cost solutions pooled with donors or government, or by requesting assistance from the Insurance Education Working Group of the Micro-insurance Network.
- Utilise mobile technology for education (e.g., text messaging) to keep costs down and reach scale.
- Develop guidelines to standardise rollout of education and include the time and location based on clients’ convenience.
- Measure the effectiveness of consumer education on knowledge, behavior, utilisation, renewals, etc.

Consumer education should be simple, long-term, and integrated with product delivery.

Consumer education requires up-front planning, dedication of resources, and partnership building.

### 4. Enrolling and retaining clients

Positive experiences through word-of-mouth and claims can increase client uptake, use, and potentially retention.

Clients value simplicity and on-the-spot enrollment.

VAS shows promise in improving enrollment and retention.

Family discounts are a promising way to increase uptake.

Time-bound premium subsidies may increase uptake but questions on sustainability prevail.

- Encourage forums for experience-sharing among clients, to increase awareness and uptake of insurance by uninsured.
- Ensure that enrollment is simple, and conducted at a time and place convenient to clients.
- Where possible, ensure on-the-spot enrollment and provision of ID cards.
- Identify VAS that offer most promise to clients, and can complement the delivery of HMI products.
- Understand household/cultural preferences for enrolling family members and design products to ensure maximum, equitable coverage.
- Where necessary, seek long-term funding from governments or local stakeholders, gaining clear commitments on the amount and duration of the subsidy.
2. ENSURING VALUE TO CLIENTS: EXPANDING PRODUCT BENEFITS

This chapter lays the foundation for how practitioners should keep a focus on ensuring high-value for clients. It addresses the non-clinical delivery of health microinsurance, including:

- Putting in place a client-value orientation
- Developing high-value products, tailored to context and need
- Defining the benefit package, with the right mix of preventive, primary secondary and tertiary care
- Pricing the product by finding a balance between coverage and affordability
- Overcoming indirect barriers to accessing care

A focus on client value should be at the heart of any insurance program, though few maintain this in practice.

By and large, HMI schemes do not routinely measure client value across different dimensions—starting from product design to distribution, linkages to health care providers and satisfaction with services, the degree of financial protection offered to households, to the point at which clients renew coverage. While plenty of academic studies have reviewed HMI schemes, these tend to focus on particular thematic areas such as health care quality or changes in out-of-pocket expenditures (Magnoni & Zimmerman, 2011a). Given the gaps in knowledge around drivers of insurance and retention, it is important for HMI schemes to continuously review whether clients value their services and note improvements in financial protection and access to health care. Below are examples of two methodologies that can help institutions measure client value internally, and at a relatively low-cost: the PACE framework and the Client Math methodology.

The PACE framework (Product, Access, Cost and Experience), developed by the ILO's Microinsurance Innovation Facility, allows practitioners to systemically assess the product and processes, and support a client-centered delivery of insurance. It evaluates the product, its cost, access, and overall experience according to five criteria (Matul et al, 2012):

- Is it appropriate to the market, and tailored to the clients' risk-management needs?
- Is it easy to access, with simple delivery and information?
- Is it affordable, and does it offer good value for money?
- Is it responsive in terms of prompt claims settlement and client queries?
Is it simple to understand and use, given the literacy levels of the community?

Recent findings from an application of the PACE framework in India suggest that community-based schemes in India (including Uplift and VimoSEWA) provide the most “balanced” client value, given their use of VAS (including health education), strong customer relationships, and quality care management (Ibid). Two government sponsored schemes that were included in the study, Yeshasvini and RSBY, scored high on their ability to deliver at affordable cost—given their large public subsidies—but underperformed on access and overall experience for clients (Ibid).

The PACE tool is focused on using administrative data within institutions and rating each dimension against a defined scale; however, it does not capture clients’ assessment of whether the product offers value. Thus, institutions should consider using complementary methods at different points in time, such as the Client Math methodology.

Developed by the MILK, Client Math is an example of a low-cost technique that uses client surveys on small, carefully selected samples of insured and uninsured groups, to gain insights about how they cope with unexpected events. It helps to explain the role that insurance plays in the financial lives of the insured after a shock takes place (Magnoni & Chandani, 2012a, 2012b). Two Client Math studies that examined how households coped with hospitalisation in India found that the financial protection offered by insurance weighed small in relation to the full costs borne by clients, where lost income was particularly significant and irrecoverable. However, there are indications that HMI offered access to better quality healthcare providers (Ibid).

**OPEN QUESTIONS**

- How can HMI schemes cost-effectively measure different dimensions of client value, as part of their routine operations?
- What industry-wide benchmarks for client value are appropriate and feasible for HMI schemes to use?

**Designing high-value, tangible products**

Client involvement is instrumental in product development.

HMI schemes are experiencing that client involvement is necessary for good product design, ownership, and self-regulation.

Member-managed initiatives, in particular, are finding that clients are best positioned to design products that meet their own needs and ration benefits in-line with their affordability. In the PWDS scheme in India, members opted for a co-payment option to avoid excessive claims and limit costs that were partially borne by members (PWDS Learning Journey). An example of a tool that can be used by communities is called Choosing Health Plans All Together (CHAT); it is an interactive game that was developed by the Micro Insurance Academy (MIA) to help communities assess their most common health needs and risks, and define a benefit package that best addresses these. In addition to product design, involving clients in decision making instills ownership and demonstrates their understanding of risk pooling (e.g., Uplift India).

While commercial insurers may not shift decision making on product features to the community, at a minimum it is advised that they engage with clients to understand their health care needs, preferences, and willingness to pay. Focus group discussions, engagement during community meetings (in the case of CHBIs or cooperatives), or interactions that are sched-
uled during loan repayments (where an MFI is the distribution channel) can serve important forums to solicit insights from clients.

**Clients value payment methods that are quick, timed with their income cycles, and bundled with other services.**

The burden of making premium payments can be alleviated for clients if payment schedules are aligned with their income cycle. SSP in India found that seasonality influences the willingness to pay and enroll in health insurance, especially in agricultural communities (SSP Learning Journey). Programs should be aware of the earning seasons (harvest time) and months when spending increases (festivals or weddings), and schedule enrollment and premium collection periods accordingly.

HMI schemes should also consider bundling premium payment with other services such as savings and loans, to minimise transactions. For example, the Zurich Bolivia Group has introduced a savings-based premium collection method with their partner BancoSol in Bolivia, whereby the premium is deducted from the savings account. It includes a 60-day grace period during which the MIS automatically attempts to deduct the premium from the policyholder’s account (Leatherman et al, 2012). In Kenya, in the Bima ya Jamii program (offering inpatient health, accidental death, and funeral), almost 90 percent of polices were purchased jointly with a loan from savings and credit cooperatives. While considered to offer convenience for clients, bundling products can also carry the risk of cross-selling credit services and lead to excessive client debt (Matul et al, 2012).

Programs should closely monitor how premium payment methods affect client satisfaction and behavior. Where MFIs distribute the product, such as in Jordan with MicroFund for Women, clients preferred to align premium payments with their scheduled monthly loan repayment rather than pay the full premium up-front (MFW Learning Journey). On the flip side, the CARE Foundation in India found that monthly premium payments altered clients’ expectations of the product and actually diminished value when they did not use the services in a given month. There was also a high lapse rate in the product resulting in a high administrative cost to the insurer (Care Foundation, Learning Journey). To ensure sustainability of the service, programs should monitor their own administrative costs associated with offering flexible premium payments, and balance it with client value.

**Clients value products that are simple to access and tangible.**

The greater the tangibility of a product – through outpatient discounts, hospital cash, or access to subsidised drugs – the higher the value perceived by clients. In Jordan, MicroFund for Women learned that its mandatory hospital cash product for borrowers was easily understood and was seen as a positive benefit of a loan (MFW Learning Journey). In Kenya, Cooperative Insurance Company provided its informal sector members a daily cash compensation for the duration of their hospitalisation, to help offset their lost income (Matul et al, 2012).

Recent evidence from Client Math studies in India suggests that clients who benefit from insurance with a tangible service or claim, tend to perceive great value in a product even when the payout is small relative to the full cost of the shock they experience (Magnoni & Chandani, 2012). Experiences also indicate that preventive services are less popular among clients than therapeutic value-added services, such as free or low-cost outpatient consultations or drugs (Pott & Holtz, 2013).

The next table is a summary of the different types of products with the pros and cons associated, from the client’s point of view.
### Table 2

**Pros and Cons of HMI Products From a Client’s Perspective**

<table>
<thead>
<tr>
<th>Product</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital cash</strong> <em>(per diem, amount varies by scheme)</em></td>
<td>Easy to understand, administer, and access; high tangibility when clients receive cash in hand</td>
<td>May not be sufficient to bridge the financial gaps that families face during hospitalisation</td>
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<tr>
<td></td>
<td>Cash can be used to meet indirect expenses such as transport, loss of income, or special diets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Can be easily bundled with other financial services, loans, or savings</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient cover – reimbursed</strong> <em>(e.g., surgery, maternity care)</em></td>
<td>Clients are more aware of costs and as a result may place higher value on coverage</td>
<td>Having to pay cash up-front can be a potential barrier to access</td>
</tr>
<tr>
<td></td>
<td>Can foster greater client engagement as client is likely to scrutinise costs and services when paying up-front and filing for a reimbursement</td>
<td>May discourage early and/or less costly (outpatient) treatment</td>
</tr>
<tr>
<td></td>
<td>Can prevent over-utilisation of services</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient cover – cashless</strong> <em>(e.g., surgery, maternity care)</em></td>
<td>Delivers enhanced client value by reducing out-of-pocket (OOP) expenditures</td>
<td>Can increase risk of moral hazard and fraud by client and provider (see note on page 29*)</td>
</tr>
<tr>
<td></td>
<td>Can increase access to health care, especially for high-cost events requiring high OOP</td>
<td>Clients may underestimate the value of coverage since the amount paid on their behalf is not known</td>
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<tr>
<td></td>
<td></td>
<td>May discourage early and/or less costly (outpatient) treatment</td>
</tr>
<tr>
<td><strong>Outpatient cover</strong> <em>(e.g., consultations, low-cost supplies, and/or diagnostic services)</em></td>
<td>Discounted or free services can offer high value and tangibility to clients</td>
<td>Can encourage over-utilisation unless appropriate limits in place</td>
</tr>
<tr>
<td></td>
<td>Gatekeeper function can enhance preventive care, and lead to earlier and less costly treatment</td>
<td>Can increase the cost of the premium for clients</td>
</tr>
<tr>
<td><strong>Preventive health services</strong> <em>(e.g., education, check-ups, health camps)</em></td>
<td>Can induce use of simple, inexpensive interventions to prevent common illnesses <em>(e.g., boiling water or using deworming tablets)</em></td>
<td>Clients may not immediately value preventive services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>May be costly to deliver at scale</td>
</tr>
</tbody>
</table>
Lessons Learned and Good Practices in Health Microinsurance

*Note:* Experiences from across countries have demonstrated that cashless services offer high client value; however, there are also downsides to this type of product. The SSP program in India, for example, observed that claims were approximately 20-30 percent higher when benefits were provided on a cashless basis compared with reimbursement. Clients perceived inpatient cashless services to be “free”, and were less likely to visit an outpatient clinic, which required an out-of-pocket contribution (albeit discounted). Hospitals felt that they could count on the payment from the insurer and were more likely to over treat [SSP Learning Journey]. Similarly, at Uplift India, clients (who are also managers of their own schemes) preferred a reimbursement model because of their increased ability to manage costs [McGuinness et al, 2011].

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**Optimising benefits**

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*The composition of benefits - preventive, primary, secondary, and/or tertiary care – will influence demand and health treatment-seeking behavior.*

One of the factors that influence whether clients will enroll in a given scheme is their perception of the product benefits. It is therefore important that insurers understand the needs and health status of clients, where they currently seek care, and whether they have access to public insurance schemes or services that can complement HMI coverage. Given that the incidence of hospitalisation is low across HMI programs, the perceived value for this product is also low—and should encourage schemes to consider expanding benefits beyond hospitalisation.

Besides influencing demand, the composition of benefits also affects how clients seek treatment. Where follow-up care is not included in a benefit package, for example, clients are typically unwilling to consult with their doctors after an admission [Magnoni & Chandani, 2012]. This can have serious implications on the overall efficacy of treatment and drive up costs for the insurer.

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*Insurers should offer coverage that extends beyond hospitalisation.*

Expenditures on primary health care typically pose a large burden on poor families, who prefer outpatient coverage. In Maharashtra, India, for example, over 40 percent of clients who enrolled in SSP’s insurance scheme, which offered outpatient health care, also had access to the subsidised RSBY scheme, which only offered inpatient secondary level cover [SSP Learning Journey].

Outpatient coverage protects families from minor but frequent shocks and expenditures. It can also improve their health and well-being by encouraging regular screenings, early diagnosis, and timely care [Leatherman et al, 2012]. These behaviors can ultimately help to manage costs for the insurer, especially where inpatient coverage is already included in the package. This has been the experience with Gonoshasthaya Kendra (GK) in Bangladesh [Interview, GK]. Similarly, in India, VimoSEWA observed that one-third of its hospitalisations were for common, preventable illnesses such as malaria, waterborne illnesses, and gastro-enteritis [Pott & Holtz, 2013]. Insurers should thus understand the root causes of illness in a given context and aim to provide a mix of primary, preventive, and secondary care that best addresses their clients’ needs.

While outpatient and preventive services are costly to implement, their long-term return on inpatient claims and renewal rates are promising—calling for additional research to prove this linkage and offer cost-effective solutions to deliver these services [Pott & Holtz, 2013]. The RSBY program in India is piloting an outpatient program in Odisha and Gujarat, studying its effect on health-seeking behavior and inpatient service utilisation, with potentially important policy implications [RSBY, 2012].
Lessons Learned and Good Practices in Health Microinsurance

HMI programs should encourage women to join, and offer cover that is specific to women’s needs.

Women are generally more susceptible to health risks, especially related to pregnancy and gynecological issues, and they are also more likely to care for other sick family members. HMI products that are tailored to meet women’s needs can increase uptake as well as improve health-seeking behavior at the household level (Banthia et al, 2010). The precise selection of benefits for women should reflect the health risks of a particular population. In Guatemala, for example, Aseguradora Rural learned during its product development phase that the main health concerns of prospective female clients were cancer, diabetes, heart problems, and hypertension, with maternal health care being less relevant (Aseguradora Rural, Learning Journey).

By and large, however, female clients place a high value on maternity benefits (Banthia et al, 2010). Such coverage can promote institutional deliveries and potentially reduce maternal and infant mortality (Smith & Sulzbach, 2008), though the cost of providing these services is rarely sustainable. For example, in Pakistan, AKAM found that even though women valued a product that included maternal care from skilled birth attendants, they were unwilling to pay the full cost of the product, which therefore required a significant subsidy.

While many HMI schemes exclude deliveries, impose waiting periods of 9 months or more, or exclude the first birth given the higher risk of complications, some are able to offer more comprehensive benefits. BancoSol in Bolivia, for example, provided full maternity coverage with a 7-month waiting period, giving pregnant women a 2-month window to purchase insurance. As a large MFI with a membership of nearly 200,000 clients, BancoSol was able to negotiate these terms with Zurich Insurance⁴, and quickly demonstrated the viability of such a program through a pilot test. In the two years since that pilot, BancoSol’s HMI program reached over 14,000 clients, with a majority of its clients being women (Banthia et al, 2010).

In Guinea, UMSGF learned that it was unable to sustain a comprehensive safe-motherhood product whose benefits included deliveries as well as ante- and post-natal care. The network expected that the product, which was mandatory at the village level, could be sustained in large villages with a high penetration rate; however, the operational costs still exceeded necessary membership volumes. The mutuals are seeking external funding and trying to enlist higher-income groups to expand the cross-subsidy, though the task has so far proven to be a challenge (UMSGF Learning Journey).

OPEN QUESTIONS

- What impact does outpatient care have on inpatient claims costs over time?
- How can outpatient care be offered cost-effectively at scale?

⁴ In January 2012, Zurich Insurance exited the partnership, giving ownership to its Bolivian insurance partner that continues to work with BancoSol.
Pricing products and balancing coverage with affordability

Pricing products to reflect their true costs is necessary for their long-term provision.

Finding a way to finance and deliver appropriate, efficient, and effective health care is more of an art than a science, and requires continuous planning and adjustment. Schemes tend to price products in isolation, without understanding cost structures or how the broader context (including the availability of public health programs) factor in. Product pricing requires a clear understanding of costs and ability to deliver effective medical services.

Many HMI schemes miscalculate pricing of products, resulting in premiums that are set either too high or too low. Underpricing typically results from estimating what clients can pay, rather than on what is required to cover costs, reach scale, and ensure adequate margins for sustainability. For example, the Karuna Trust in India established a premium that was too low and proved unsustainable without generous subsidies (Radermacher et al, 2005). Over pricing can occur with flawed data, overly cautious margins, or projections that aim to break even in too short a period of time or with too few lives enrolled (McCord et al, 2007; Leatherman et al, 2012).

Even when HMI programs price products according to valid cost estimates and program inputs, the reality that many clients simply cannot afford premiums may mean that schemes scale back their benefits, identify subsidies to bridge operational gaps, introduce efficiencies with technology or bulk purchasing of drugs, or partner with public sector programs for certain services.

Directly subsidising premiums can distort the market, unless carefully integrated with public sector support.

Testing and innovation in the use of subsidies for HMI is underway, with little conclusive evidence on what works and does not work. Early lessons suggest that direct subsidies that cover premium costs can distort the market for HMI services, limiting programs to a given geography where the subsidy can be applied, and more critically, affecting demand in the wider market.

Implementers of subsidised HMI schemes reveal that it is difficult to introduce premiums for insurance that were initially provided at a nominal charge or discount (Interview, PharmAccess Foundation; Radermacher et al, 2005). Given this effect, subsidies to the premium should be considered only in cases where they are provided over the long term, ideally with commitment from local governments. Preferably, where subsidies are required, they should be used to build the institutional capacity of HMI schemes, such as management information systems, provider capacity building or to offer a discrete service, such as a health care hotline (e.g., Uplift, India). Subsidies should be continuously monitored so they do not induce long-term inefficiencies within an organisation, which can take the form of relatively high distribution or claims costs.

Several small-scale HMI schemes are testing whether cross-subsidies or sponsorships from employers to informal workers can be effective. In Pakistan, Naya Jeevan works with employer groups (especially small and medium enterprises) to offer sponsorships for their workers to access benefits beyond the usual scope of hospitalisation insurance, such as day-care emergency surgeries, medical screening, 24/7 telehealth line, health education workshops, discounted drugs, and outpatient services (Naya Jeevan Learning Journey). In Kenya, Africa, Medilink and the PharmAccess Foundation are working with tea producers. The tea producers are contributing...
the full premium for over 5,000 tea workers thus giving the workers access to health care. The Foundation supports the marketing and provider management of the scheme in the initial years (Interview with PharmAccess Foundation). Neither initiative is sustainable yet, in large part due to their limited scale.

OPEN QUESTIONS

- What is the cost of efficient and effective health provision versus the prevailing “market price”? How can HMI schemes improve their own management and thus impact product pricing?
- How can HMI schemes effectively introduce subsidies while limiting long-term distortions in the market?
Addressing indirect costs and other barriers

Relative to medical expenses, indirect costs associated with obtaining care can be large.

Client-level research on HMI schemes reveals that there are high indirect costs to accessing health care—even if the product and price are “right.” These include non-medical expenses incurred for transportation, special diet, and perhaps most significantly, opportunity costs in the form of lost income (Magnoni & Chandani, 2012, Ranson 2005). While hospital cash products may address some of these needs, in general, they fall short of covering the full range of costs.

HMI practitioners should consider introducing product features such as transportation allowances, savings-linked products (so that people make provisions for lost income during hospitalisation), and, where possible, linkages to public social security schemes for greater protection. Also, by networking with health providers or community workers that are located in the vicinity of clients, or introducing telemedicine models, health care can increasingly reach the doorstep of clients and thus reduce some of their indirect expenditures. Such services also offer high tangibility and can potentially increase value for clients (Pott & Holtz, 2013). Finally, where HMI schemes can impact the quality of care provided in the public sector, they can help to improve long-term access barriers for low-income populations (Ranson 2005; Interview, GK).

Other barriers to care include lack of knowledge about a product and how to use it, awareness of which providers belong to the HMI network, and the steps required to obtain care.
ENSURING VALUE TO CLIENTS: 
EXPANDING PRODUCT BENEFITS SUMMARY

<table>
<thead>
<tr>
<th>What we have learned</th>
<th>How-to steps</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Focusing on client value</strong></td>
<td></td>
</tr>
<tr>
<td>Client-value should be at the heart of any insurance program, though few schemes maintain this in practice.</td>
<td>Assess the different methodologies that can be used to review client value and select 1-2 that are appropriate for your organisation.</td>
</tr>
<tr>
<td></td>
<td>Appoint a team to manage and review different dimensions of client-value: satisfaction with the product and claims process, quality medical care, and how it affected household finances [e.g., avoided borrowing or selling assets].</td>
</tr>
<tr>
<td><strong>2. Designing high-value, tangible products</strong></td>
<td></td>
</tr>
<tr>
<td>Client involvement is instrumental in product development.</td>
<td>Hold discussions with clients to review their satisfaction with the product and determine their preferences regarding product delivery, cost, and benefits.</td>
</tr>
<tr>
<td>Clients value payment methodologies that are quick, timed with their income cycles, and bundled with other services.</td>
<td>Involve clients in defining product coverage and costs using the CHAT or other tools.</td>
</tr>
<tr>
<td>Clients value products that are simple to access and tangible.</td>
<td>Collect payments in alignment with the income cycle of clients, balancing the administrative costs to the organisation.</td>
</tr>
<tr>
<td></td>
<td>Bundle premium payments with other services, such as loan repayments, or distribution of sales proceeds to cooperative members, to gain efficiencies.</td>
</tr>
<tr>
<td><strong>3. Packaging an optimum mix of benefits</strong></td>
<td></td>
</tr>
<tr>
<td>The composition of benefits - preventive, primary, secondary, and/or tertiary care - influences demand and health-seeking behavior.</td>
<td>Hold discussions or surveys with clients to understand their health-seeking behavior, access to services and public entitlements [such as free deliveries], household, risk-coping strategies.</td>
</tr>
<tr>
<td>Offer coverage that extends beyond hospitalisation, including VAS.</td>
<td>Consider adding outpatient benefits or VAS, such as discounts for consultations or drugs, as well as expanded coverage for women.</td>
</tr>
<tr>
<td>Encourage women to join, and offer cover that is specific to their needs.</td>
<td>Introduce VAS one at a time, and sequentially with HMI products, to allow adequate focus.</td>
</tr>
<tr>
<td></td>
<td>Calculate the cost of offering outpatient coverage and monitor how inpatient claims are affected as a result.</td>
</tr>
<tr>
<td></td>
<td>Understand the particular health concerns faced by women and the cost of including coverage.</td>
</tr>
</tbody>
</table>
Lessons Learned and Good Practices in Health Microinsurance

4. Pricing products and balancing coverage with affordability

Price products to reflect their true costs to ensure they can be provided over the long-term.

- Collect data needed for pricing decisions, including organisational costs, service delivery costs, morbidity data, population data, and information about public health programs that clients’ access.
- Through willingness-to-pay or other tools, determine client affordability for the product and whether benefits need to be scaled back.
- Work with health-care providers to determine if services can be delivered more effectively to improve quality and reduce cost.
- Identify gaps and potential sources of subsidies, including public sector partnerships or employer contributions.

Integrate public sector support when directly subsidising premiums.

- How can HMI schemes cost-effectively measure different dimensions of client value as part of their routine operations? What industry-wide benchmarks for client value are appropriate and feasible for HMI schemes to measure?
- What impact does outpatient care have on inpatient claims costs over time? How can outpatient and inpatient care be offered cost-effectively at scale?
- What is the cost of efficient and effective health provision versus the prevailing market price? How can improved management of HMI schemes impact the pricing of a product?
- How can HMI schemes effectively introduce subsidies, while minimising long-term distortions in the market?

5. Addressing indirect costs and other barriers

Indirect costs associated with obtaining care can be large, relative to medical expenses.

- Through client discussions or surveys, assess how indirect costs, such as transport and lost-wages, affect the health-seeking behavior of clients.
- Create a list of strategies that may mitigate these costs, and estimate the cost and benefit of each for a confined pilot area.
- Seek input from clients on whether there are other barriers to seeking care, related to product awareness or confidence using it.

Questions that deserve further investigation
3. ENSURING VALUE TO CLIENTS: DELIVERING HIGH QUALITY MEDICAL SERVICES

This chapter focuses on the second dimension of client-value, the delivery of medical services. It includes a discussion of the following aspects of service delivery:

- Improving medical information, linkages, and service quality
- Networking with medical facilities and health workers
- Accréditing providers and standardising care
- Managing the supply of pharmaceuticals
- Using technology to increase efficiencies and deliver care

**Improvıng medical information, linkages, and service quality**

HMI schemes can improve access to different health providers and potentially improve the quality of care.

Insurance coverage can expand access to the types of health providers from which clients seek health care. In Karnataka, India, clients insured through Grameen Koota were able to access larger, private facilities that they were unlikely to use without insurance (Magnoni & Chandani, 2012). Similarly, in Ghana, members enrolled under the NHIS were more likely to visit a doctor over a chemist (FFH, Learning Journey). However, changing the source of care does not necessarily imply improving its quality. Recent research in India found virtually no difference between trained and untrained doctors in their adherence to medical checklists or likelihood to diagnose and treat properly, suggesting the need to improve “provider-effort” through payment terms or other incentives (Das et al, 2012). Where programs are engaged in accreditation and capacity building (discussed further below), expanding access can lead to a qualitative improvement in services. In India, evidence from Uplift shows that network hospitals maintain better health infrastructure, treatment facilities and compliance with protocols, but do not necessarily hire better lead doctors (as measured by their qualifications, years of experience, and medical knowledge) (Bauchet et al, 2010).

HMI schemes can create an expectation of high quality but not deliver on their promise, with serious implications on client retention. In Guinea, UMSGF experienced a steep increase in enrollments after adding a primary care benefit to their product. However, the government health posts were unable to meet the demand for care that followed. Clients regularly dealt with a shortage of medicines and
poor customer care, leading to nearly half dropping out of the scheme after one year (UMSGF Learning Journey).

**Tangible VAS, including health education and outpatient care, can improve access and quality of medical care.**

Tangible VAS, including health education and outpatient care, can improve access and quality of medical care. Services such as medical camps, access to health information hotlines, and outpatient discounts can improve the value proposition for clients, ensure rapid medical attention, and also promote healthy behaviors (Pott & Holtz, 2013). For example, in Uganda, Microcare distributed insecticide-treated bed nets at subsidised rates to its policyholders so that they could see a tangible benefit of their coverage even if they did not make a claim; it also reduced the incidence and treatment costs of malaria (ILO, 2010). These types of VAS encourage higher renewals over time. A recent review of VAS programs highlights the importance of sequencing VAS before or after core HMI coverage to ensure adequate focus (such as instituting a hospital cash product followed with a telemedicine service, or vice versa).

Similarly, the authors also recommend that HMI schemes should introduce and test discrete VAS one at a time (Pott & Holtz, 2013).

**Linkages with the broader health system can help improve HMI scheme viability and rationalise the delivery of care.**

Linkages with the broader health system can help improve HMI scheme viability and rationalise the delivery of care. HMI schemes should consider ways to complement the delivery of existing public health services, to avoid duplication and keep costs down. For example, in countries where certain medical services are free, such as deliveries or family planning products, HMI schemes can consider creating referral linkages to public facilities. Such efforts can minimise costs and potentially improve the quality of care at participating public hospitals (Ranson, 2005; Bauchet et al, 2010). In other cases, HMI schemes can offer complementary coverage to what is offered through the public sector; for example, by offering primary and secondary care where tertiary care is subsidised, or vice versa. In India, various states are starting to “wrap-around” services to RSBY, by testing outpatient services and introducing specialised tertiary health care that is not included under the base package (Wharton, 2012).

In many contexts, the delivery of health services is constrained by limited health personnel, weak infrastructure and service quality, and poor drug supply (Leatherman et al, 2012). Typically, health supply is dominated by the presence of informal providers such as drug shops and community health workers, with fewer inpatient facilities, diagnostic centers, and hospitals. HMI schemes should consider engaging with provider groups that are underutilised in the formal health care system such as traditional birth attendants, to increase efficiencies, potentially improve the quality of care delivered by these professionals and help rationalise the overall delivery of care.

**OPEN QUESTIONS**

- What are effective strategies to scale-up delivery of VAS?
- How can HMI leverage use of existing health care services (e.g., midwives-birthing centers)?
- How can HMI complement government insurance programs?
- When linkages are present, can HMI induce higher-quality care in public facilities?
Networking with medical facilities and health workers

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The choice of health providers can help an HMI scheme meet its access, affordability, and health care quality objectives.

Providers can include large public or private hospitals, solo-practitioner clinics, community health workers, and other gatekeepers. HMI schemes should identify the appropriate mix of providers based on the context and its own objectives. For example, a scheme that aims to reach rural populations may have to develop a hub-and-spoke model with community agents who are located in remote areas. Clients value geographic proximity to providers, which should form an important criterion in provider selection (UMSGF, Learning Journey; SSP, Learning Journey).

There are a number of factors that will determine a provider’s willingness to join an HMI scheme, including the size of the member base, payment and reporting terms, their current occupancy rates and whether there are opportunities for upgrading skills or processes (such as in medical record management) and promoting their facilities. In India, SSP found that larger hospitals were more compliant with HMI billing processes than smaller ones, and they were also better able to tolerate variable or longer periods to receive payment than smaller facilities (SSP Learning Journey).

Providers are typically willing to negotiate discounts if there is a promise of higher patient flow or regular capitation payments, and if they have greater unused capacity; in other cases, providers may be more willing to offer discounts if a clear social objective of the scheme is articulated (SSP Learning Journey). The provision of training and stepwise quality improvement process upgrades can also motivate providers to join a network, as is the case with Hygeia in Nigeria (Interview, PharmAccess Foundation).

Where HMI schemes network with large hospitals that typically serve more affluent people or those covered under health plans sponsored by employers, it may be necessary to advocate on behalf of poorer patients to ensure that they receive equitable treatment and attention. Such high-interaction advocacy efforts need to be priced into the model and can be a barrier to scaling-up (Naya Jeevan Learning Journey).

HMI schemes should understand which providers deliver care to their clients, what incentives they respond to, and the trade-offs presented by each cohort in terms of quality, cost, physical access, or other variables.

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Engaging with alternative health professionals can improve viability and client value.

In many contexts, the lack of sufficient medical doctors means that much of health care is delivered through nurses, paramedical staff, community workers, chemists, and traditional health providers. Increasingly, HMI schemes are starting to engage with these “alternative” health providers given their willingness to work in remote, underserved areas at relatively low cost, and consequently serve as gatekeeper in the scheme. When health workers are recruited from the community, they typically enjoy greater trust and are more approachable for clients. Recent evidence from India that finds only nominal differences in the quality of care between providers with formal medical training and those without, offers an additional case for engaging with alternate provider groups (Das et al, 2012).
### Table 3

**HEALTH PROVIDER CHARACTERISTICS**

<table>
<thead>
<tr>
<th>Category of provider</th>
<th>Provider incentive to join network</th>
<th>Quality and scope of care</th>
<th>Cost of care</th>
<th>Physical access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospitals</td>
<td>Service utilisation</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Public clinics (in &amp; outpatient)</td>
<td>Service utilisation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private hospitals</td>
<td>Service utilisation Promotion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private clinics (in &amp; outpatient)</td>
<td>Service utilisation Promotion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacies</td>
<td>Product sales Promotion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug shops/chemists</td>
<td>Product sales Promotion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community health workers</td>
<td>Service utilisation Service ethic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traditional health providers</td>
<td>Service utilisation Service ethic</td>
<td></td>
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</tr>
</tbody>
</table>

- Low
- Medium
- High

Ultimately, the choice of providers that an HMI scheme engages with will depend on an assessment of four demand and supply factors, including:

- What do clients prefer in terms of services, proximity, and affordability?
- Which particular providers are best positioned to deliver care against these criteria at a price point that matches the premium?
- Which cadres can most effectively serve as a gatekeeper for clients?
- What opportunities are presented for upgrading certain alternative health cadres?
A common challenge for HMI schemes is the lack of regulation and standardisation of health care delivery.

In many contexts, performance standards for health care providers are lacking and governments’ ability to regulate is constrained by resources or capacity (Leatherman et al, 2012). Thus, typically the onus is on HMI schemes to introduce protocols for standardisation of care and systems for regular monitoring and oversight. Depending on the type of HMI model and the partners involved, this function can be managed by the risk carrier (MHO, NGO or commercial insurer), the TPA, and on rare occasion, by the delivery channel (e.g., Jamii Bora in Kenya or the Healing Fields Foundation in India). For community-managed schemes that rely on volunteers or part-time staff, these quality assurance functions typically fall outside their core capacity and can significantly raise costs (Bauchet et al, 2010; UMSGF Learning Journey).

HMI schemes should understand the factors that drive provider behavior, besides economic ones, and introduce systems to manage their behavior. For example, the type of medical training that a provider has undergone and when, and what their peers are doing, will certainly affect their medical practice. HMI schemes can help providers standardise and improve care by developing treatment protocols, conducting routine audits and offering training—all dependent on the capacity of the HMI scheme. These inputs can be linked to performance-based contracting, which can help to standardise implementation.

Regular monitoring is integral to maintaining quality standards. Various dimensions of quality should be routinely assessed and supported, including leadership management, clinical service delivery, rational drug use, facility management, and patient care.

Box 5

The advantages of working with alternate health cadres

In Bangladesh, the Gonoshasthaya Kendra (GK) model places paramedics as the foundation of a health care team. GK recruits and trains young women from the community who have between 6–10 years of education on a full range of preventive and basic curative services including immunisations, sanitation, nutrition, reproductive health, and family planning, as well as the use of 50 essential medicines. GK pairs the paramedics with traditional birth attendants to offer maternal health care including deliveries and counseling on breast-feeding. Besides offering medical care, they promote insurance in the community and collect premiums. The paramedics are trusted in the community and have easy access into homes of people from different social classes (Interview with GK).

The IKP Centre for Technologies in Public Health (ICTPH) in Tamil Nadu, India, has developed a primary health care model with health extension workers and alternative Ayurveda, Siddha and Unani (AYUSH) physicians. AYUSH doctors are legally permitted to practice allopathic medicine once trained, but are severely underutilised in the current health system. ICTPH trains and certifies these doctors on evidence-based protocols so that they can serve as “independent-care providers” in a rural setting. To support the doctors, ICTPH also trains health extension workers on specific skills to manage patient triage, follow-up visits, and community engagement activities (Interview with ICTPH).
A combination of rewards and penalties can help enforce quality standards.

Providers respond to positive, motivational incentives and to penalties—both dependent on the negotiating power of HMI schemes. In finding the balance between incentives and penalties, HMI schemes should take into account norms in a given context, and their own capacity to manage quality assurance.

The SafeCare Initiative – a partnership between the Joint Commission International (JCI), the PharmAccess Foundation, and the Council for Health Service Accreditation of Southern Africa (COHSASA) – is a capacity-building program designed to enhance accreditation and standards in low-resource health settings across Africa. SafeCare has developed standards that are specific for different types of facilities, including hospitals, nursing homes, dispensaries, and mobile clinics. The standards require participating facilities to first meet a certain “compliance” benchmarks; subsequently, facilities maintain standards to qualify for upgrades in their certification, and finally to achieve accreditation. The stepwise recognition of quality improvement is delivered hand-in-hand with technical assistance and training, and used as the basis for performance based financing.5

In Nigeria, the PharmAccess Foundation is implementing the SafeCare program with Hygeia Community Health Care. An important driver for providers to join is the potential to upgrade their facilities, earn brand recognition, achieve higher patient traffic, and access financing (for example, from the Medical Credit Fund) to make capital improvements [Interview with PharmAccess Foundation]. The possibility of losing status as an accredited provider can also induce providers to adhere to treatment standards and billing protocols. Under the RSBY scheme in India, insurers are increasingly revoking the accreditation of hospitals, mostly due to medical malpractice or inflated billing, but also because they fail to meet basic facility standards. To date, over 270 of the 10,000 hospitals have lost their accreditation nationally (RSBY).

OPEN QUESTIONS
· Can HMI schemes drive up health care quality by allocating resources to higher-performing providers and crowding out substandard ones? What are proven strategies to achieve this?

Box 6

Example of components of quality of care

1. Health care organisation management
   · Management and leadership
   · Human resource management
   · Patients’ rights and access to care
   · Management of information
   · Risk management

2. Care of patients
   · Primary health care services
   · Inpatient care

3. Specialised services
   · Operating theatre and anesthesia services
   · Diagnostic and imaging services
   · Medication management

4. Ancillary services
   · Facility management services
   · Support services, including counseling

5 See: http://www.safe-care.org/
Pharmacy management and drug supply

Drugs comprise a major source of costs for clients and HMI schemes.

The high costs of drugs affect the viability of HMI schemes and pose a heavy burden on households. In India and Pakistan, drugs comprise up to 70 percent of client outpatient expenditures and a similar share of total out-of-pocket spending on health (Pott & Holtz, 2013; Shahrawat & Rao, 2011). This high burden of costs is also reflected among HMI schemes: at VimoSEWA India, drugs comprise up to 50 percent of expenses; at the CARE Foundation also in India, drugs are expected to drive up to 70 percent of outpatient claims costs (Care Foundation Learning Journey, SEWA Learning Journey). Thus, the unit cost of drugs as well as the frequency and type of prescriptions represent a significant, even majority, of expenditure by clients and HMI schemes. These high costs are driven by several factors, including:

- Large margins imposed by pharmaceutical companies
- Supply chain constraints (e.g., inability to procure in bulk, poor transport or storage infrastructure, and risk of pilferage)
- Doctors’ tendency to overprescribe, using branded drugs
- Clients’ high demand for medications

Partnerships with manufacturers or distributors, though difficult to negotiate, can help maintain steady and lower-cost supply.

Partnerships with pharmaceutical companies, wholesalers, distributors, or the public sector can help improve access to drugs and keep costs affordable—though these are difficult to structure and rarely seen in practice. Partnerships with pharmaceutical companies, in particular, are challenging given entrenched interests by providers and companies to deliver high-margin, high-cost drugs—and to increase sales on the whole.

HMI schemes that have a larger base of members and a wider network of contracted providers have greater leverage to structure these partnerships. In Guatemala, the Aseguradora Rural reached an agreement with a pharmacy network to deliver drugs at discounts of up to 50 percent (Aseguradora Rural Learning Journey). In Pakistan, Naya Jeevan was also able to negotiate rates at wholesale prices; however, the reduction was not high enough to be considered of much value by clients (Naya Jeeavan Learning Journey). Similarly, in India, discounts on branded medications are rarely negotiable beyond 5-10 percent, not adding significant value to clients. By contrast, in Africa, retail pharmacy margins range between 40-60 percent – so a discount of half that amount can translate to significant savings (Pott & Holtz, 2013). Several large-scale franchise initiatives that are focused on increasing the supply of low-cost generic drugs, including the Government-owned Jan Aushadi scheme in India and Generics Pharmacy in the Philippines, offer promising partnerships with HMI schemes in the future (Ibid).
Motivating providers to rationalise prescriptions – including use of generics – can cut costs and improve quality.

Rational management of drugs—medications appropriate to need, prescribed at the right dose for the right length of time—and available at lowest cost can improve quality for patients, reduce their out-of-pocket expenditures, and improve efficiencies within HMI schemes.

There is evidence of HMI schemes shifting risk to the provider to manage prescriptions as well as those that promote rational prescription use. In Tanzania, through a scheme managed by MicroEnsure and the PharmAccess Foundation, clinics provide drugs under a fixed capitation rate and take on the risk of managing cases. Providers have an incentive to rationalise drug use, but are also able to procure drugs in bulk with their monthly lump-sum capitation payments, an arrangement that they were previously unable to negotiate with suppliers (Interview, MicroEnsure). In India, SSP learned that employing health providers on a full time basis was necessary to control their prescribing behavior, and ultimately costs for the scheme (SSP Learning Journey).

In Guinea, UMSGF created a mutual stock of drugs for their health centers, which shifted risk to the centers themselves to manage prescriptions. As a result, there was a drop in the prescription rate from 14% to 2% over two years (UMSGF Learning Journey). Regulations on the distribution and management of drugs may prohibit or limit such arrangements in other countries. For example, in India, the CARE Foundation and SSP failed in their efforts to set up pharmacies because of licensing restrictions (CARE Foundation Learning Journey; SSP Learning Journey).

In Bangladesh, the Gonoshasthaya Kendra focuses on a rational drug use system whereby they develop a list of recommended essential, generic drugs, and maintain strict audits to confirm that prescriptions are justified and appropriate. Doctors are paid a fixed salary, thus have no incentive to over-prescribe. The scheme also educates clients on the comparability and efficacy of generic drugs, to change demand patterns (Interview, GK).

Changing clients’ perception of the need for drugs is an important component to rationalising use.

From the client’s point of view, medicines are tangible and therefore considered a desirable component of health care. HMI schemes should educate clients about prevention and the optimum use of pharmaceuticals, especially antibiotics. Along the same lines, clients may also perceive generic or alternate brands to be of poorer quality. Thus, HMI schemes may need to advocate around the issue, and educate clients about the efficacy of non-branded equivalents. If clients trust the doctor or the clinic’s reputation, their likelihood of willingly switching brands or using different type of drugs has shown to be greater (SSP Learning Journey).

Open Questions

- What strategies, or combination of strategies, have proven to be most effective in rationalising drug prescriptions and use?
- What are ways to supply low-cost, high quality drugs in different markets?
- How can excessive margins for branded drugs be circumvented?
Using technology to improve efficiencies and deliver care

Technology presents significant opportunities to gain efficiencies and improve quality of information and services.

There are numerous applications of technology in HMI schemes, spanning from enrollment, premium and data collection, to fraud detection, information dissemination and the delivery of care. These functions have a crosscutting impact on service quality as well as institutional sustainability, (discussed further in Section 4). While pockets of innovations in the use of technology are emerging (highlighted below), relative to the number of HMI schemes operating, few are effectively utilising technology to manage information, control fraud, or improve the quality of care. This limited use of technology is most apparent among HMI schemes in Africa (Leatherman et al, 2012).

Where technology is employed, one common function is in automating the enrollment of members into HMI schemes, which reduces costs, captures robust data, and offers greater convenience and service quality to clients. For example, in India, the RSBY program uses technology to facilitate client-authentication, on-the-spot enrollment and distribution of biometric smart cards. In Tanzania, an HMI scheme managed by the PharmAccess Foundation and MicroEnsure completes client enrollment using tablets while capturing key data about clients through a survey tool (Interview, MicroEnsure). The system enables the scheme to verify clients as soon as the data is downloaded on the server, and identify inconsistencies up-front. The scheme also collects premiums every month via a mobile cash transfer system (Ibid).

Mobile phones are being used to inform clients about health issues, to provide referral advice, and to help them adhere to drug regimens. For example, in partnership with MTN, Project Masiluleke in South Africa sends out a million text messages daily, promoting an HIV/AIDS hotline that directs clients to clinics outside their local region, where they can avoid the stigma of getting tested among peers (Economist 2009). In Thailand, a health program that sent out text messages to remind its patients to adhere to their tuberculosis drug regime achieved compliance of over 90 percent (Leatherman et al, 2012). At the Uplift Mutual, a low-cost telephone hotline serviced by doctors is able to prevent some hospitalisations and gives clients immediate access to medical consultations (Bauchet et al, 2012).

Finally, technology is enabling HMI schemes to deliver care through telemedicine. The CARE Foundation in India has created a hub and spoke model whereby village health workers use technology-enabled diagnostic protocols delivered through hand-held terminals to provide medical advice and prescriptions, complemented by real time support from doctors over mobile phones (Leatherman, 2012; Pott & Holtz, 2103). In the process of using technology, the Foundation learned that live testing of hardware solutions was required in the field (which was a rural context where connectivity was limited) to identify challenges up-front. They also recognised that more interaction was needed between vendors who developed clinical decision support software and those who developed the front and back end interfaces (Care Foundation Learning Journey). The proliferation of stand-alone telemedicine companies globally is expected to offer promising linkages for HMI schemes in the future (Pott & Holtz, 2013).
### ENSURING VALUE TO CLIENTS: DELIVERING HIGH QUALITY MEDICAL SERVICES SUMMARY

<table>
<thead>
<tr>
<th>What we have learned</th>
<th>How-to steps</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Medical information, linkages, and service quality</strong></td>
<td></td>
</tr>
<tr>
<td>HMI schemes can improve access to cadres of providers and potentially improve quality.</td>
<td>Solicit client feedback to determine the VAS features that can be bundled to the core product; for example, medical camps, discounts, or promotions.</td>
</tr>
<tr>
<td>Tangible VAS, including health education and outpatient care, can improve access and quality of health care.</td>
<td>Map all the players involved in delivering health care in your locality, as well as public sector schemes that clients may benefit from.</td>
</tr>
<tr>
<td>Linkages with the broader health system can help improve HMI scheme viability and rationalise the delivery of care.</td>
<td>Engage in discussions with these groups to understand their scope of services and interest to participate in an HMI scheme.</td>
</tr>
<tr>
<td><strong>2. Networking with medical facilities and health workers</strong></td>
<td></td>
</tr>
<tr>
<td>The choice of health providers can help an HMI scheme meet its access, affordability, and health care quality objectives.</td>
<td>Understand and rank clients’ preferences for sourcing health care; how do cost, quality, proximity, and trust factor in?</td>
</tr>
<tr>
<td>Alternative health professionals can offer a high-value proposition in the delivery of HMI.</td>
<td>Match these criteria with the current landscape of providers to determine which provider cohort, or combination, may be most suitable.</td>
</tr>
<tr>
<td></td>
<td>Survey different cadres of providers to understand their willingness to join.</td>
</tr>
<tr>
<td></td>
<td>Begin with a homogenous network. Expand and diversify by testing in phases.</td>
</tr>
</tbody>
</table>

### Questions that deserve further investigation

- What are effective strategies to scale-up delivery of value-added services? Which type of VAS are more conducive for reaching scale?
- How can HMI schemes drive up health care quality in a given market?
- How can HMI leverage use of existing health care services (e.g., midwives-birthing centers)?
- How can HMI complement government insurance programs? When linkages present, can HMI induce high-quality care in public facilities?
- What strategies, or combination of strategies, have proven to be most effective in rationalising drug prescriptions and use? What are ways to supply low-cost, high quality drugs in different markets? How can excessive margins for branded drugs be circumvented?
3. Accreditation of providers and standardisation of care

A common challenge for HMI schemes is the lack of regulation and standardisation of health care delivery.

A combination of rewards and penalties can help to enforce quality standards.

- Appoint a medical professional (or team) to lead the quality assurance function, including setting and monitoring standards.
- Assess the quality of care and level of adherence to standards among providers, and determine gaps and opportunities.
- Review existing clinical protocols, accreditation checklists, and monitoring tools that can be tailored to your HMI scheme.
- Identify the technical support and systems strengthening that providers will need.
- Develop a plan, with a balance of carrots and sticks, to motivate providers to adhere to quality-of-care protocols and standards.
- Introduce channels to obtain client feedback about the quality of health care.

4. Pharmacy management and drug supply

Drugs comprise a major source of costs for clients and HMI schemes.

- Learn who the key stakeholders are in the supply and regulation of pharmaceuticals and the supply gaps.
- Create a short list of prospective partners and engage in discussions on their interest to affiliate with an HMI scheme, by offering discounted drugs.
- Appeal to their bottom line, whether it is CSR, increased market share to low-income segments, or brand promotion.
- Rationalise prescriptions through the payment model (capitation or fixed salary versus fee-for-service) and through training providers.
- Include advocacy for clients on rational drug usage, including use of generics.

5. Using technology to deliver information and care

Technology presents significant opportunities to gain efficiencies and improve quality of information and services.

- Identify opportunities to utilise technology to manage data, interface with clients for enrollment and health education, or to deliver care through telemedicine.
- Engage with specialised technology partners to build systems, starting simple with management of information.
- Test all devices in the field where the HMI scheme will operate, to identify challenges up-front.
Lessons Learned and Good Practices in Health Microinsurance
4. ACHIEVING INSTITUTIONAL SUSTAINABILITY

This final chapter will discuss the institutional structures and systems necessary to deliver health insurance over the long term, including:

- Structuring the organisational model
- Instituting contracts and payment mechanisms
- Administering policies and claims
- Controlling adverse selection, moral hazard, and fraud
- Ensuring continuous monitoring
- Interfacing with regulation and policy

Structuring the organisational model

Experimentation in the structure of HMI models continues to inform the sector.

There are open questions about the viability of HMI and the sector is learning from experimentation across countries. What is clear is that the type of model and the effectiveness of its management are key determinants of its impact on the community and viability— affecting its pricing, benefits, and long-term funding (Leatherman et al., 2012). As programs gain experience, they may evolve in their organisational structure. For example, several HMI schemes in India, including Self Help Promotion for Health and Rural Development (SHEPERD), transitioned from a partner-agent to a community-based model; the latter afforded greater flexibility and community involvement—features that were deemed important for their objectives. On the other hand, SSP evolved from a community-based model to a hybrid model in which it retained a community health fund for outpatient care but sought a commercial group insurance policy for high-cost events; however, with high claims and low enrollment, it was unable to meet its projections for scaling up (SSP Learning Journey).

The players involved in delivering HMI – commercial insurers, community-based organisations, delivery channels, TPAs, and health care facilities – each carry different core competencies. All partners should recognise the value proposition in each other and build on their strengths. For example, delivery channels that are closer to the client are better positioned to handle marketing and client education, while risk-carriers can centralise and manage processes around information technology and product development. HMI schemes are also outsourcing TPAs, particularly in India (e.g., Yeshasvini Cooperative) to oversee claims management and health providers.
Public-private partnerships are a promising way to achieve scale and sustainability.

Public-private partnerships (PPPs) can draw on the strengths of each sector to catalyse approaches that can serve a larger base of people. The private sector can offer value in bringing operational efficiencies, technical and management know-how, and close contact with the customer; the public sector has the ability to aggregate large segments of the population for programs to achieve scale, channel public financing, and enhance regulation of the sector, including providers.

There are emerging experiences with private HMI schemes demonstrating success in pilots and drawing public sector support. In Nigeria, the PharmAccess Foundation has gained support of the government in Kwara state to scale-up its pilot HMI program. The state government has committed a contribution of up to 80 percent of the premium for qualifying enrollees (with possible contributions from other donors) and is now positioned to scale-up the program from 60,000 to 600,000 lives (Interview, PharmAccess Foundation).

Such partnerships with local government are a promising way to serve vulnerable groups over the long term, and also bring the potential for replication to other local government units. Like any PPP, however, such initiatives are subject to changes in political priorities and resource commitments.

**Instituting provider contracts and payment mechanisms**

Provider payment methods can impact scheme viability and potentially quality of care.

Engaging with health providers is at the heart of any HMI scheme—with the potential to impact the cost and quality of health-care delivery. There are essentially three payment

**Figure 1**

Reimbursement model (Le Roy & Holtz, 2012)
models that are used to engage with providers: a reimbursement model, a third-party payment (TPP) model, and an integrated care and financing model. TPP models are the most prevalent, followed by reimbursement models and schemes that utilise a combination of payment types (Le Roy & Holtz, 2012).

Under a reimbursement model, clients pay for services out-of-pocket and submit claims and receipts to the HMI scheme for reimbursement. The relationship between the HMI scheme and provider may be less formal and simpler to administer, given that payments are not channelled between the two parties. Examples include Uplift in India and Jamii Bora in Kenya.

Under a third-party payment (TPP) model, the risk-carrier (or another party such as TPA) pays the provider on behalf of the insured. Clients obtain health care on a cashless basis, with the exception of any co-payment or deductible. TPP models promise high client value because they reduce the up-front payout from families, avoid the inconvenience of waiting for reimbursements or the risk of having a claim denied in part or altogether (Le Roy & Holtz, 2012). However, TPP models are more complex to set up and manage, and are more prone to moral hazard by providers and clients who may provide or seek unnecessary care. Examples include First Microinsurance Agency Pakistan and Yeshasvini, India.

Another structure under which cashless services are offered is the integrated care and financing model. In this case, HMI schemes are embedded within health care facilities and clients are typically restricted to a particular provider. Clients pay a premium to the HMI scheme or provider and qualify for cashless services as defined in the benefit package.

Though limited in the scope of health services and scalability, the model can ensure high quality services and access for targeted communities. Examples include the Nkoranza Community Financing Scheme in Ghana and the Bwamanda Hospital Insurance Scheme in the Democratic Republic of Congo.
Best practices around payment methodologies are largely drawn from case reviews of existing programs rather than empirical research. By and large, the evidence is more conclusive about the effect of payment methods on cost-management (discussed below), and less so about the effect on provider satisfaction, retention, or the quality of services delivered.

A recent global review of payment mechanisms within CBHI schemes does offer an important insight on the non-financial impact of payment methods (Robyn et al., 2012a): Provider participation and satisfaction increased when there was greater consensus among providers on the choice of payment method, and clear communication about why a particular method was selected. Engaging with health providers about their preferences for payment methods, before structuring the terms, can lead to greater alignment (Robyn et al., 2012b).

Provider payment methods can be structured in several ways: retrospective or prospective of service delivery, and in some cases by transferring financial risk to the provider. They include:

- Fee for services used; limited to what is covered in the policy (e.g., Uplift India)
- Fee for cases seen; an all-inclusive amount paid per episode of care (e.g., UMSGF, Guinea)
- Reimbursement per day; an all-inclusive amount paid for hospitalisation (e.g., BASIX, India)
- Prospective payments per enrollee (i.e., capitation); a fixed amount over a fixed period, paid per life or family covered (e.g., PharmAccess Foundation, Tanzania)

Fee for service payments are the most prevalent, but are usually associated with an increase in the volume of services and overall expenditure—by giving providers a financial incentive to increase the volume of services delivered (Le Roy & Holtz, 2012; Robyn, 2012b). In contrast, payment methods that transfer some financial risk to providers (case-based, per day or capitation) have greater potential to contain costs and incentivise providers to become more efficient; for example, capitation can encourage early and less costly treatment by providers. Capitation can be particularly appropriate to compensate providers for

Payment methodologies that align financial and service incentives between parties can help contain costs.

The choice of payment method and how it is implemented in a given context will certainly impact the management and viability of a scheme. HMI schemes should identify the simplest payment method available while recognising that no single set of incentives can address the multiple objectives of HMI schemes, providers, and clients (Langenbrunner et al., 2009).
primary health care (covering high frequency, low-cost events), given that it is possible to predict how often people may require such care, and estimate associated costs. It can also ease administrative costs since claims are not submitted. Capitation may be more suited for environments where providers are scarce and where a critical mass of enrollment can be achieved with a given provider (Le Roy & Holtz, 2012). Depending on the basket of services that are covered, a combination of payment models, such as capitation for primary care and case-based coverage for hospitalisations can be used (Le Roy & Holtz, 2012).

In Tanzania, the PharmAccess Foundation and MicroEnsure instituted a capitation payment model to cover primary care for members of rural cooperatives that the program is serving. They found that establishing capitation contracts with providers was difficult up-front, given the uncertainty around utilisation and providers’ resistance to assume financial risk. Despite observing spikes in utilisation in the early months, as the scheme rolled out and its risk pool expanded, over 50 percent of the providers’ patients were members of the scheme. With this leverage, MicroEnsure was able to negotiate a reduction in capitation rates; in addition, it had better information about the actual costs that providers incurred to deliver care, which helped to refine the pricing (Interview, MicroEnsure).

GRET-SKY in Cambodia, an HMI scheme that received support from the Ministry of Health, instituted a capitation system to ensure access to primary health care (including outpatient services) for the target population. Initial negotiations with providers were aided by a financial guarantee, whereby GRET-SKY agreed to compensate providers for any financial losses in the first year if charges exceeded the capitation amount. However, anecdotal feedback indicates that the capitation rate was set higher than other schemes, which may prove unsustainable to finance.

The next table summarises the pros and cons of each payment type from the perspective of the provider and HMI scheme (Le Roy & Holtz, 2012).

**OPEN QUESTION**

- What is the impact of provider payment methods on provider satisfaction and retention, and on the quality of care they deliver?
### PROS AND CONS OF PROVIDER PAYMENT METHODS

<table>
<thead>
<tr>
<th>Method of payment</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee-for-service</td>
<td>Easy to understand and implement; typically the method used by health-care providers</td>
<td>Drives up costs by providing a financial incentive to:</td>
</tr>
<tr>
<td></td>
<td>Encourages provision of services, which can aid access to care for low-income households</td>
<td>- Over-utilise services (in volume)</td>
</tr>
<tr>
<td></td>
<td>Generally well accepted by health-care providers</td>
<td>- Raise billed charges if these are the basis for calculating payments (increase unit costs)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- HMI scheme bears entire financial risk and may try to restrict claims by limiting covered services or by being prone to reject claims</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Can require unpopular interventions to reduce inappropriate claims</td>
</tr>
<tr>
<td>Per case</td>
<td>Simplifies claims administration</td>
<td>Incentive to diagnose and bill for more complex (higher revenue) cases</td>
</tr>
<tr>
<td></td>
<td>Transfers financial risk for length of stay to providers</td>
<td>Incentive to reduce length of stay and services that may be necessary</td>
</tr>
<tr>
<td></td>
<td>Encourages efficient care management (shorter length of stay)</td>
<td>Incentive to make unnecessary admissions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Difficult to establish a fair cost per case for all patients (i.e., including outliers)</td>
</tr>
<tr>
<td>Per day</td>
<td>Simplifies claims administration; an entry product that insurers can enhance over time</td>
<td>Incentive to increase length of stay</td>
</tr>
<tr>
<td></td>
<td>Transfers financial risk for cost per day to providers</td>
<td>Incentive to reduce services that may be necessary</td>
</tr>
<tr>
<td></td>
<td>Encourages efficient care management (lower intensity of service per day)</td>
<td>Incentive to make unnecessary admissions</td>
</tr>
</tbody>
</table>
## Administering policies and claims

**Administrative systems require dedication of resources and can benefit from the use of technology.**

The systems that support the policy and claims administration begin at the point of client enrollment, and extend to premium collection, claims payments, and renewals. The greater the use of technology to collect and analyse data across these points, the higher the efficiency and timeliness in service delivery, accuracy in data, and value for the client. For instance, by conducting client enrollment on-the-spot, institutions can avoid inputting and reconciling paper forms, and can capture important client data and medical history in one interface (Interview, MicroEnsure, Tanzania).

Experience shows that adequate resources need to be dedicated for customising and testing technology solutions, including claims management software, so it works for a given HMI product (CARE Foundation, Learning Journey). Similarly, claims forms and processes should be updated and tested as new products are developed, to encourage efficient processing and payment of claims (Aseguradora Rural, Guatemala).

HMI schemes should continuously review and align their management structures to improve administration of policies and claims.

<table>
<thead>
<tr>
<th>Method of payment</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capitation</td>
<td>Simplifies claims administration (no claims necessary)</td>
<td>Providers generally unreceptive due to inability to manage financial risk of care</td>
</tr>
<tr>
<td></td>
<td>Steady revenue stream (prepayment) for providers (cash-flow advantage)</td>
<td>Difficult to price accurately without large enrollment due to high variation in cost to care for small numbers of patients</td>
</tr>
<tr>
<td></td>
<td>Allows the transfer of financial risk to health-care provider</td>
<td>Incentive to reduce care</td>
</tr>
<tr>
<td></td>
<td>Encourages providers to provide preventive care and encourage earlier and less costly treatment</td>
<td>Incentive to exclude high-risk groups (elderly, persons living with HIV/AIDS, those with preexisting and chronic diseases in some cases)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Encourages inappropriate referral to other providers for expensive cases when not all health care is covered by the capitation payment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Can be difficult for insurer to obtain utilisation (encounter) data to reconcile payments with actual experience</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Difficult to ensure that providers comply with service agreements with the client</td>
</tr>
</tbody>
</table>
For example, while Microcare Uganda was operational, it restructured its claims administration team to increase efficiencies, and decided to focus on five core functions.

As HMI schemes scale-up, they commonly outsource services to third-party administrators.

Policy and claims administration requires specialised expertise and is commonly outsourced to TPAs, particularly as schemes reach scale and their provider networks expand, or when they provide cashless benefits to clients. In India, the rapid scale-up of RSBY is attributed in part to the localised strengths of TPAs that understand the political and geographic landscape of different districts (Krishnaswamy & Ruchismita, 2011). Moreover, given its sheer size (of having subscribed over 30 million families to date) insurance companies contracted under the RSBY scheme also partner with firms that exclusively oversee member enrollment and distribution of smart cards. In some contexts, however, the costs of working with TPAs can be prohibitive and not worth the service value for HMI schemes.

OPEN QUESTIONS

- To what extent can and do TPAs add value to the delivery of HMI services? What types of HMI models and geographies can obtain most value from a TPA partnership, and in what cases can these functions be managed internally?
- What is a reasonable level of investment that an HMI scheme should devote to technology, given its growth and scale projections?
- How can Cloud technology solutions help with the management of claims data?

Box 7

Claims administration by Microcare in Uganda

Administrative units took responsibility for each function:

- **Invoicing**: claims were matched with provider invoices and discrepancies investigated.
- **Data entry**: data from claims were entered onto the database to immediately verify that they were under acceptable limits.
- **Data analysis**: claims reviewed by a medical doctor to ensure appropriate diagnosis and treatment and prescription of drugs; questionable claims were dealt with separately to not hold up the entire batch.
- **Investigation**: a team followed up with providers to resolve questions and obtain outstanding data.
- **Reporting**: approved claims were sent to a supervisor for final review and payment, signaling request for the accounts unit to initiate payment.

(Le Roy & Holtz, 2012)
Controlling moral hazard, adverse selection, and fraud

A robust management information system can help an HMI scheme to manage costs related to adverse selection, moral hazard, and fraud.

Moral hazard and fraud are inherent in most HMI schemes, though varied according to the incentives and controls in a given model. In cashless models, where clients typically perceive services to be “free”, utilisation costs tend to exceed the risk premium. Providers may try to limit care in capitation models or prescribe longer stays or unnecessary treatment in reimbursement models. Fraudulent behavior can occur across levels, with providers charging for services not rendered, or clients providing false receipts or misrepresenting their identity. Enrollment protocols can also provide opportunities for misuse and adverse selection. For example, under the NHIS in Ghana, people who have lapsed in paying their premium can pay the arrears and access care immediately, resulting in members avoiding to pay their premium up-front (FFH Learning Journey).

HMI schemes thus need to carefully understand the likely behaviors of providers and clients under a given payment method, and introduce relevant measures to limit adverse selection, moral hazard, and fraud. There are several broad strategies that can be used to limit such behavior among providers and clients (summarised below). In all cases, appropriate IT systems will help to monitor trends in utilisation, services rendered, eligibility of clients and quality of care, and trigger questionable cases of overuse or fraud. In all cases, dialogue with providers is essential to control fraud and education with clients to reduce moral hazard.

Continuous tracking can help programs to flag certain procedures that emerge as a primary driver of claims and costs. For example, VimoSEWA in India observed a high rate of hysterectomies in its portfolio, and was unsure whether these were clinically necessary. The scheme created a specific preventive health “intervention” to educate women as to the clinical indications for hysterectomy. Also, it instituted a “second opinion” feature to encourage clients to validate with a government physician or a VimoSEWA health worker if a hysterectomy recommended by a provider was supported by medical evidence. While these checks were necessary to prevent unnecessary hysterectomies, VimoSEWA was unable to establish whether their rates were higher or lower than state standards given the lack of reliable benchmark data on expected hysterectomy rates (SEWA Learning Journey).
### Table 5

**ILLUSTRATIVE CONTROLS TO LIMIT MORAL HAZARD, ADVERSE SELECTION, AND FRAUD**

<table>
<thead>
<tr>
<th>Provider level</th>
<th>Client level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moral hazard: institute product limits</td>
<td>Moral hazard: institute product limits</td>
</tr>
<tr>
<td>Limit maximum benefits for hospital care, balanced with sufficient cover</td>
<td>Introduce co-payments or other cost sharing</td>
</tr>
<tr>
<td>Limit services to frequent health issues (under capitation)</td>
<td>Control coverage limits and benefits and ensure full disclosure to clients</td>
</tr>
<tr>
<td>Conduct periodical audits</td>
<td></td>
</tr>
<tr>
<td>Claims administration and fraud control: monitor data and flag outliers</td>
<td>Adverse selection: impose enrollment limits</td>
</tr>
<tr>
<td>Number and cost of claims: total, segmented by client category, location, provider, type of service etc.</td>
<td>Introduce waiting periods and fixed enrollment windows</td>
</tr>
<tr>
<td>Frequency and cost per unit: number and cost of hospital admissions</td>
<td>Offer group-based products (especially when mandatory) or enroll a large percentage of target population</td>
</tr>
<tr>
<td>Average length of stay: days per admission</td>
<td></td>
</tr>
<tr>
<td>Incurred claim ratio: incurred claims/earned premium</td>
<td>Fraud control: identity verification</td>
</tr>
<tr>
<td>Billed charges as a per cent of total capitation (for schemes with capitation)</td>
<td>Introduce use of ID cards with photographs or smart cards that prove eligibility</td>
</tr>
<tr>
<td></td>
<td>Use liaison officers at health facilities to verify eligibility and rotate staff at intervals to avoid collusion</td>
</tr>
<tr>
<td>Medical management</td>
<td>Medical management</td>
</tr>
<tr>
<td>Pre-authorisations</td>
<td>Use gatekeeper to refer clients for specialist care</td>
</tr>
<tr>
<td>Use of treatment guidelines</td>
<td></td>
</tr>
<tr>
<td>Capitation or case-based payment structures</td>
<td>Pre-authorisations for hospitalisations, but risk to delay care</td>
</tr>
</tbody>
</table>

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6 Adapted from Le Roy & Holtz, 2012. Provider level column may not necessarily correspond with Client level column.
Ensuring continuous monitoring and evaluation

A combination of activities, including routine data collection, onsite supervision, and one-off studies, is needed to keep programs on track.

As discussed above, routine monitoring is essential to detect cases of moral hazard and fraud. Monitoring is also critical to track the overall performance and viability of an HMI scheme, as well as the medical and financial value that it delivers to clients. When the systems are strong and quality of data high, the more able the managers to adapt products, delivery systems, and the quality of care over the course of implementation.

Performance measurement and analysis of HMI schemes can be categorised in two dimensions: scheme performance and client value. A starting point to assess scheme performance is reviewing key performance ratios over time, which are categorized as follows (Wipf et al., 2010):

- **Product value**: incurred claims, incurred expenses, and net income ratios
- **Product awareness and satisfaction**: renewals, coverage of the poor, growth in enrollment
- **Service quality**: promptness of claims settlement and claims rejection ratios
- **Financial prudence**: solvency and liquidity ratios

Other indicators of scheme performance relate to the delivery of medical services, management information systems, and human resource capacity and development.

On the client value side, HMI schemes should monitor service utilisation, including access to care, satisfaction with care, client out-of-pocket expenses (including medical and non-medical indirect costs), and where possible, long-term health outcomes.

Measuring quality of care is not always simple. It requires a combination of data analysis and onsite supervision. Routine data can inform providers about utilisation trends, common illnesses and trends in morbidity, typical length of stay, and cost of care per admission or episode of care. Onsite monitoring of providers to verify adherence to treatment protocols or facility upkeep can complement these data. Obtaining feedback from clients about the care they receive and their perception of quality is also important.

One-off studies to complement data collection can improve the HMI scheme’s implementation over the long term. For example, intensive reviews or scientific evaluations may focus on whether health education actually leads to behavior change, or enhanced primary care leads to improved health outcomes. In both examples, the findings can affect how resources are allocated (more or less client education) or what the benefit package should include (more or less preventive, primary care).
By linking practice and policy, HMI schemes can support the development of favorable regulatory frameworks.

Many regulatory frameworks for microinsurance pose barriers to entry, formalisation, and growth of the sector—for example; they may take the form of high capital requirements for risk-carriers or licensing barriers for delivery channels. Insurance frameworks also vary to the degree that they have specific regulations for HMI. In India, for instance, there is no explicit policy for community-based health insurance, which means that they are unsupervised— one of the reasons they are unable to scale up or federate.

HMI schemes that have credible field experience and/or are aligned with each other can influence the development of supportive policies. In Ghana, a number of CBHI schemes were rolled under the National Health Insurance Scheme, thereby expanding the scale of the national program (Robyn et al. 2012a) and potentially leveraging community solidarity. Similarly, in Guinea, the UMSGF network is coordinating closely with the state to define the possible features of a prospective universal health coverage bill (UMSGF Learning Journey). In India, the proposal for universal health care recommends an alternative approach to the one followed by RSBY (i.e., from management by private firms to a model in which central and state governments centralise the purchasing of care with the aim to avoid fragmentation and cost inflation). Over time, this can entail a shift in function by insurers from financing and service delivery to capacity building of Ministries to manage provider networks (Planning Commission, India, 2011).

As the debate unfolds, it is imperative for HMI schemes to coordinate with each other and collectively maintain policy dialogue with national bodies, thus promoting best practice and aligning the delivery of health care over the long-term.
### ACHIEVING INSTITUTIONAL SUSTAINABILITY SUMMARY

<table>
<thead>
<tr>
<th>What we have learned</th>
<th>How-to steps</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Structuring the organisational model</strong></td>
<td></td>
</tr>
<tr>
<td>Experimentation in the structure of HMI models continues to inform the sector.</td>
<td>Identify opportunities for improving HMI services through different structures or new partnerships: e.g., are there better-suited delivery channels for the target population?</td>
</tr>
<tr>
<td>Public-private partnerships are a promising way to achieve scale and sustainability.</td>
<td>Determine public sector health financing priorities and gaps; identify leaders who are open to testing a PPP approach and advocate for replication of successful pilots.</td>
</tr>
<tr>
<td></td>
<td>Define clear performance driven terms of engagement with partners, public or private.</td>
</tr>
<tr>
<td><strong>2. Instituting provider contracts and payment mechanisms</strong></td>
<td></td>
</tr>
<tr>
<td>The scope of the provider network and payment structures is fundamental to scheme viability.</td>
<td>Determine the choice of providers to network, based on client demand and available supply.</td>
</tr>
<tr>
<td>Payment methodologies that align financial and service incentives between parties are needed for a strong delivery model.</td>
<td>Assess provider capacity to manage different payment methods.</td>
</tr>
<tr>
<td></td>
<td>Determine the payment model based on provider capacity, benefit package, client needs, and availability of TPAs, if needed.</td>
</tr>
<tr>
<td></td>
<td>Identify appropriate incentives and disincentives to optimise provider and client behavior.</td>
</tr>
<tr>
<td></td>
<td>Institute clear and collaborative contracts with checks and balances built in.</td>
</tr>
<tr>
<td><strong>3. Administering policies and claims</strong></td>
<td></td>
</tr>
<tr>
<td>The systems that cut across the life of a health policy are extremely important, though not always afforded the necessary resources or attention.</td>
<td>Streamline operations related to policy and claims administration, ensuring sufficient IT and management resources.</td>
</tr>
<tr>
<td>As HMI schemes scale up, they commonly outsource third-party administrators.</td>
<td>Continuously align internal management to increase efficiencies.</td>
</tr>
<tr>
<td></td>
<td>Utilise technology solutions to improve data quality, efficiencies, and early warning signals.</td>
</tr>
<tr>
<td></td>
<td>Determine costs and benefits of outsourcing TPA functions, as needed.</td>
</tr>
</tbody>
</table>
Lessons Learned and Good Practices in Health Microinsurance

Questions that deserve further investigation

- What is the impact of provider payment methods on provider satisfaction, retention, and on the quality of care?
- Can and do TPAs add value to the delivery of HMI services? What types of HMI models and geographies can obtain most value from a TPA partnership, and in what cases can these functions be managed internally?
- What is a reasonable level of investment that an HMI scheme should devote to technology, given its growth and scale projections?
- How can Cloud technology solutions help with the management of claims data?

4. Controlling costs, moral hazard and fraud

A robust management information system can help an HMI scheme to manage costs related to adverse selection, moral hazard, and fraud.

- Understand the incentives and disincentives for clients and providers to overuse services.
- Institute appropriate limits in product design, client enrollment and identity verification, claims administration and medical management.
- Introduce technology to improve controls and offer early warning signals for fraud or over-utilisation.
- Assign responsibility to committee/units to manage and monitor these functions.

5. Continuous monitoring and evaluation

A combination of strategies, including routine data collection, site supervision, and one-off studies, is needed to keep programs on track.

- Develop a monitoring plan, with clarity on the different types of M&E systems and responsibilities.
- Review routine data on performance ratios, financial statements, and utilisation data.
- Ensure regular site checks for quality assurance.
- Conduct one-off studies to look more intensively at a given question or process.

6. Interfacing with regulation and policy

By linking practice and policy, HMI schemes can support the development of favorable regulatory frameworks.

- Understand laws and regulations related to organisational models for HMI (capital requirements, etc.), regulation of medical service quality, and pharmacy management.
- Identify opportunities to engage in policy-level debates to strengthen the regulatory environment and partnerships.
CONCLUSION

Health microinsurance (HMI) schemes around the world are pushing the frontiers by reaching underserved groups, providing health care that clients increasingly value, including outpatient care and VAS, utilising technology to enhance service delivery, learning how to co-manage risk with health providers, and understanding the trade-offs that are needed to sustain HMI.

The rich experiences from the field, many of which have been documented and highlighted in this report, should continue to guide and inspire practitioners.

The process of taking stock has also led to the discovery of new questions and areas for future experimentation. With these, and many other questions, the HMI sector stands ready for a fresh round of collective learning and growing.
ADDITIONAL RESOURCES


Adverse selection
A phenomenon according to which persons with a greater-than-average risk of illness or maternity enroll in a HMI scheme in a higher proportion than that of their share of the target population, and/or choose the highest levels of coverage.

Beneficiary
A person who, in his or her capacity as a member or dependent, benefits from the services of a HMI scheme.

Benefit
The health insurance coverage that a HMI scheme agrees to provide in exchange for the payment of insurance premiums.

Branded drugs
A pharmaceutical substance protected by a patent and sold under a brand name chosen by the manufacturer.

Capitation
A method of payment for health services in which an individual or institutional provider is paid a fixed, per capita amount for each person treated, regardless of the actual cost of the services provided.

Case-based payment
A hospital payment method that reimburses hospitals a predetermined fixed rate for each treated case.

Claim
A request for payment under the terms of an insurance contract when an insured event occurs.

Claims ratio
The actual claims divided by the risk premium. Insurers generally prefer for the claims ratio to be less than 100 percent, that is, actual claims to be less than expected claims.

Co-payment
Mechanism used by insurers to share risk with policyholders and reduce moral hazard, which establishes a formula for dividing the payment of losses between the insurer and the policyholder.

Coverage
The guarantee against specific losses provided under the terms of an insurance policy. Frequently used interchangeably with benefits or protection, coverage is the extent of insurance afforded by a policy.

Delivery channel
An entity used to deliver insurance policies and services to clients.

Enrollment period
A specified length of time during which an individual or family is eligible to apply for insurance.

Exclusions
Specific conditions or circumstances listed in the policy for which the policy will not provide benefit payment.

Expense ratio
The ratio of an insurance scheme’s operating expenses to premiums.

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Fee for service
A method of charging whereby a physician or other practitioner bills each encounter or service rendered. E.g., separate fees for consultation, medicines, laboratory or procedures.

Generic drug
A medicine designated by the name of its main active ingredient and not by its commercial name. In general, the International Non-proprietary Name (INN) established by WHO corresponds to the generic name. Generic drugs are less expensive than brand-name drugs.

Health care provider
A person or institution which physically delivers health-care goods and services (e.g., a clinic, hospital, nurse or doctor).

Indirect costs
Non-medical, out-of-pocket costs incurred by individuals when accessing medical care. These include costs for transportation, special diets as well as lost income.

Inpatient services
The care provided to a bed patient in a covered facility.

Insurance benefit
A health service whose utilisation is covered by a HMI scheme, which undertakes to pay, in whole or in part, the expenses incurred in connection with the utilisation of that service. This may refer to an individual health service, an episode of illness, or a broader range of health services.

Moral hazard
A risk that occurs when insurance protection creates incentives for individuals to cause the insured event; or a behavior that increases the likelihood that the event will occur.

Morbidity
The relative incidence of disease.

Mortality
The proportion of deaths to population.

Mutual health organisation
A scheme characterised by the broad participation of members in its management. Mutual health organisations are democratic institutions founded on the principles of mutual assistance and solidarity.

Mutual insurer
Insurance in which the ownership and control is vested in the policyholders.

Network
A grouping together of actors (schemes, trade unions, support organisations, etc.) for the purpose of carrying out activities relating to information, training, promotion, etc.

Outpatient care
Treatment provided in a hospital or clinic, but without involving hospitalisation of the patient. The patient returns home after receiving treatment.

Out-of-pocket payments
Costs borne directly by a patient who lacks insurance benefits; sometimes called direct costs. Unless covered by insurance, they include patient payments under costsharing provisions.

Premium
A fixed sum paid periodically by a member of HMI scheme in order to benefit from the services provided by the scheme and to enable his or her dependents to benefit from them.

Provider payment method
The mechanism used to transfer resources from the purchasers of health care services to the providers.
**Provider payment system**
The provider payment method combined with all supporting systems, such as information systems and accountability mechanisms, considered in the context of surrounding payment systems (for outpatient services, for example) and referral rules.

**Rational drugs use**
A system that entails that medications are appropriate to need, prescribed at the right dose and for the right period, and available at lowest cost.

**Reimbursement**
Payment by an insurance scheme to a health-care provider, or to insured persons, as a refund for all or part of fees for services.

**Reserves**
An amount representing liabilities kept by an insurer to provide for future commitments under policies outstanding.

**Retrospective payment**
The payment rate for a set of services determined after the services are delivered.

**Risk carrier**
The entity that is liable for the risk.

**Risk management**
An approach that consists of taking certain precautionary measures and organising oneself in order to deal with the future occurrence of a risk.

**Third-party administrator**
A sales and service representative who handles insurance for clients, offering back office support and claims processing for insurance companies (risk carriers), and offering clients with different insurance products.

**Waiting period**
The period of time that an individual must wait either to become eligible for insurance coverage or to become eligible for a given benefit after overall coverage has commenced.
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The Microinsurance Network is a member-based network of organisations and individuals active in microinsurance. The mission of the Network is to promote the development and proliferation of good-value insurance products for low-income persons by providing a platform for information sharing and stakeholder coordination.

The Health Working Group brings together practitioners, insurers and academics involved in the design and implementation of pooling products that increase low-income families’ financial access to health care.

For more information on the Microinsurance Network visit www.microinsurancenetwork.org

Any feedback or comments can be sent to info@microinsurancenetwork.org

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