

INNOVATIONS AND BARRIERS IN HEALTH MICROINSURANCE

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INTRODUCTION

Health microinsurance (HMI) offers a promising way to mitigate the risks of disease and ill health, which are disproportionately borne by the world's poorest citizens. Despite that HMI is a relatively new phenomenon, recent figures indicate that approximately 40 million people worldwide have some form of HMI coverage, principally in India.

The emergence of HMI programmes worldwide provides hope that the poor will receive, at a minimum, a reliable, adequate level of access to affordable healthcare. Research shows that access to HMI reduces out-of-pocket health expenses, especially for catastrophic health events, and improves access to quality health care for those who are insured. There is also evidence that HMI stimulates important health seeking behaviours such as the use of mosquito nets and receipt of malaria treatment earlier in the disease cycle. Nevertheless, little is known about the impact of HMI on health outcomes and household well-being, especially when it concerns the poorest individuals who tend to be excluded from HMI programmes and who generally receive a lower quality of care. There is still scope to expand member benefits in HMI. In so doing, low-income individuals can be better enabled to access medically necessary care at the appropriate time, thus reducing financial catastrophe and promoting economic productivity and efficient use of resources.

HMI is one of many potential healthcare financing options for the poor. Other options range from out-of-pocket spending or credit to government-sponsored partial or universal access to healthcare services.

Research indicates that 26% of households in low and middle-income countries resort to borrowing and selling assets to cover healthcare expenses, suggesting that there is a huge gap in health care financing. Although health care is increasingly perceived as a human right and a public good, the reality is one of resource constraints that slows the deployment and scale-up of national healthcare financing. In these cases, HMI can be a possible alternative; hybrid strategies that combine private sector led HMI with the strengths of the public sector also promise to push frontiers in healthcare financing for the poor.

Despite the positive indicators and potential of HMI, there are many challenges that limit the growth and impact of the sector. This briefing note, based on a longer thematic study that included a literature review of 68 documents covering the period from 1999 to 2010 and expert interviews with more than 31 experts representing 25 organizations, discusses these challenges and focuses on private sector HMI. In addition to identifying barriers to success, this note presents innovations that may move the field forward, including collaboration with public programmes.



¹ This brief is excerpted from the Microinsurance Paper No 6 available at www.ilo.org/microinsurance, which also includes all the acknowledgements and relevant citations. Sheila Leatherman works for Gillings School of Global Public Health, University of North Carolina-Chapel Hill, Lisa Jones Christensen for Kenan-Flagler Business School, University of North Carolina-Chapel Hill and Jeanna Holtz for the ILO's Microinsurance Innovation Facility.

THE COMPLEXITY OF HEALTH MICROINSURANCE

Designing valuable, sustainable products is inherently more complex for HMI than for other types of microinsurance. Most HMI products cover catastrophic risks which occur with low frequency, are often unpredictable, and result in a need for high-cost services. These catastrophic events are more easily insured than routine healthcare needs, so insurers have focused on them, often designing in-patient only coverage. However, HMI programmes struggle to reach sustainable membership for these in-patient policies, partly because the poor perceive more value in coverage for high frequency, predictable and often low-cost services. An ideal solution would optimize both needs, simultaneously reducing clients' vulnerability to catastrophes and improving overall health outcomes.



The very nature of HMI differentiates it from other forms of insurance. Rather than a payment being made to compensate for a loss, a service is delivered by a third party, the healthcare provider, who has an information advantage over both the patient and the insurer regarding the diagnosis and subsequent care of the patient. As a result, it is extremely difficult to control utilization, to ensure that the services are appropriate, and to mitigate the risk of fraud and irrational pricing. Complicating the situation, health facilities in developing countries often deliver poor quality services, which lowers impact and member satisfaction.

Key supply-side issues in HMI revolve around capital constraints, which stem from insufficient enrolment and operational inefficiency. Improper pricing, limited use of technology, and lack of reinsurance exacerbate these issues. Amidst such challenges, HMI programmes differ on many fronts : programme design, distribution and servicing approaches, and coverage or benefits. This complexity exists because different programme configurations address exigencies of different operating environments. Commercial insurers, community groups, microfinance institutions, and others involved in HMI use their particular strengths to deliver programmes to their target groups. By evaluating the current state of the sector, including these significant variations, this note identifies options for progress.

INNOVATIONS AND INTERVENTIONS FOR HEALTH MICROINSURANCE

There are a number of areas in which HMI can be improved. Many exciting projects worldwide are working in the field and testing innovative solutions such as expanding member benefits, overcoming low capacity to pay, improving efficiency to achieve larger scale, and forging collaboration between public and private sectors.

Expanding member benefits

Member benefits should extend beyond hospitalization. Minor health shocks are a pressing concern for most low-income households, and meeting this demand can increase take-up and stabilize risk pools. Furthermore, enhancing out-patient benefits encourages regular health check-ups, earlier diagnoses, and timely care for minor illnesses. These changes should reduce overall treatment costs and lower claims for in-patient products, thus improving the overall viability of HMI programmes. Several Indian organizations have developed creative solutions to address the demand for outpatient services (see Box 1).

One approach that may add value for clients with chronic conditions, which is not currently covered by HMI programmes, is to provide discounts for routine consultations and drugs (see Box 1). Not only can discounts increase perceived value and encourage renewals, they may also prevent unnecessary hospitalizations, ultimately enabling lower premiums or enhanced benefits. Another way to improve client satisfaction and health outcomes through outpatient benefits is by providing auto-generated reminders (via text messages delivered on mobile phones, for example) about preventive care or disease management.

Box 1. Comprehensive coverage through community health workers in India

Swayam Shikshan Prayog (SSP), an Indian NGO that promotes social and economic opportunities for low-income women and their families, is piloting a hybrid HMI model to overcome some of the limitations of community-based schemes. Financial risk for in-patient benefits is carried by an insurance company, bundled with a package of outpatient services, implemented by community health workers, and delivered through a network of local practitioners, diagnostic centers and drug dispensing units. The community health workers function as social entrepreneurs who promote better health and earn commissions by enrolling new members. Besides covered hospitalization services, members can receive additional health services and access outpatient primary and preventive services and drugs at a targeted 30 - 40% savings from usual charges.

Overcoming low capacity to pay

Given that affordability remains one of the key factors influencing demand for HMI, many countries support health financing mechanisms such as cost-sharing and government subsidies. Despite these options, making HMI products affordable while generating sufficient revenue to sustain operations is an ongoing challenge. Currently, the most common payment practice is to collect annual premiums at or around the time of enrolment. However, some programmes are attempting savings-linked and other approaches that improve flexibility of premium payments to overcome unique problems among the poor, such as seasonality of income (see Box 2).

Box 2. Electronic premium payment from savings in Bolivia

Zurich Bolivia Group has had much success delivering HMI products through BancoSol, a commercial bank focused on the low-income market. One contributing factor was that sales and premium payments are linked to savings accounts. The product, sold at bank offices, offers medical consultation coverage at 100%, ancillary services and maternity at 80%, and hospitalization and surgery at 70% plus life insurance for \$3.99 per month. Zurich Bolivia invested in customized management information systems to automate premium collections and integrate them with banking functions. Monthly premium collection is flexible: if the savings account has insufficient funds when a scheduled premium payment is processed, the system retries every day to debit the account until 1) there are sufficient funds to pay the premium, or 2) sixty days have gone by, in which case the policy is cancelled.

Financial constraints also need to be overcome on the claims side. One notable innovation is cashless benefits, which allow clients to access healthcare without having to pay cash up front and then file a claim for reimbursement. When an HMI programme serves a small geographic area and has sufficient scale, capacity, and operational expertise, the programme can handle the administrative burden of cashless products itself. Otherwise, HMI programmes often employ third-party administrators (TPAs) to establish direct payment arrangements with healthcare providers, to verify eligible clients, and to oversee the provision of healthcare services. The emergence of more TPAs with context-specific skills in information technology will likely help control costs in the low-margin, high-transaction world of HMI.

Another major effort to provide adequate capital is to subsidize HMI premiums. Some donors and governments experiment with temporary subsidies for health insurance (e.g. the Health Insurance Fund in Nigeria). The rationale is that clients will see the value of insurance and continue to pay for coverage once the subsidies are removed. Permanent subsidies are also targeted at poorer classes in several countries

including Georgia and Ghana. Given the inability of the poor to pay for healthcare, it is hard to imagine that valuable HMI programmes can scale regionally or globally without subsidies and other support from the public sector.

Efficiency to achieve scale

Low-income clients' high sensitivity to price means that the entire process of selling and administering HMI must be as efficient as possible. Outsourcing administration to TPAs is one approach, but technology can also be employed as a helpful tool in many aspects of operations. Nevertheless, few HMI programmes are utilizing technology and management information systems. Case studies of seven East African HMI programmes revealed that only two programmes were using computer systems to increase controls and provide management data. Aside from data management, technology can be used in other ways, such as improving access to care for rural clients (see Box 3).

Box 3. Mobile technology to connect doctors with rural patients

Based in Hyderabad, India, CARE Foundation is piloting a rural health delivery and microinsurance scheme that focuses on the provision of outpatient care in the village setting. Community members are trained to be Village Health Champions (VHCs) who provide "healthcare at the village doorstep". For routine diagnoses, VHCs use a hand-held terminal with a built-in clinical decision support system to provide appropriate medical advice and order prescriptions. In less routine cases, they liaise with a remote CARE doctor who recommends treatment through an SMS text message. Final testing of the technology, training of health workers, and product design are currently being completed. The product will be piloted in 2010, with a target outreach of 50 villages that have approximately 100,000 low-income residents by 2012.



Care Hand held terminal

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Public and private sector collaboration

Another potential solution to the challenge of offering comprehensive HMI coverage is public-private partnerships (PPPs). Research reveals that providing access to healthcare often requires the cooperation and blended competencies of the public and private sector with each having complementary resources and roles. In particular, PPPs can leverage the creativity and efficiency of the private sector in accordance with the fundraising capabilities of the public sector. Public money may be necessary to pay for most preventive care, health promotion, or to subsidize outpatient and/or inpatient care.

Public entities can also coordinate private sector players to create larger, more stable risk pools. The public sector may be able to provide enabling regulation and access to underutilized healthcare facilities that the private sector can use to expand access and lower costs, and can promulgate and enforce quality and accreditation standards. Finally, private sector management expertise can drive solutions to reduce fraud, manage programme risk and costs, and catalyze innovations across the entire HMI value chain (e.g. product development, information technology, etc.). For example, Rashtriya Swasthya Bima Yojana (RSBY), a government subsidized hospitalization scheme for the poorest in India, is delivered through private sector insurance companies. In addition, interesting developments to scale up HMI took place in Rwanda and Ghana where social insurance systems are based on previously existing community-based health schemes.

CONCLUSIONS: A COORDINATED EFFORT

Overall, the evidence review and expert interviews indicate that programmes can approach health financing either to reduce vulnerability (focusing on a catastrophic event or in-patient care) or to improve health outcomes (focusing on outpatient care, prevention, and chronic care). These two perspectives present a conundrum: the former is more aligned with principles of insurance, but the latter is desired by the clients and may produce better health outcomes. Through efficient business models, technological innovations, customized benefit packages, and varied payment plans, HMI programmes should seek a balance between the two perspectives. The solution should also leverage PPPs, combining the public sector's ability to source funding, pool large groups, and ease regulatory issues with the private sector's innovation, insurance expertise, efficiency, and technology.

Thus, the way forward for HMI lies with the combined efforts of policy-makers and governments, insurers and reinsurers, and private sector actors including technology firms, NGOs, and healthcare providers. Ultimately, no efforts are likely to be successful without constantly soliciting and utilizing input from the most important stakeholder: the potential client.

Housed at the International Labour Organization's Social Finance Programme, the **Microinsurance Innovation Facility** seeks to increase the availability of quality insurance for the developing world's low-income families to help them guard against risk and overcome poverty. The Facility was launched in 2008 with the support of a grant from the Bill & Melinda Gates Foundation. See more at www.ilo.org/microinsurance



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