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Introducing a savings-financed product -- UpLift [1]

Country of Operation: India
Region: Asia and the Pacific
Sub Topics: Business models, Other channels, Partnerships, Consumer education, Improving value, Value-added services, Savings-linked, Health

Organizational Overview

UpLift India Association (commonly known as UpLift) is a non profit company, created with the objective of setting up and accelerating community owned, bottoms up, risk sharing, protection projects. UpLift?s community plus health mutual protection model focuses on creating socially valuable business models and invests in training, education and service delivery as well as sets up operations to run risk protection models. UpLift?s founding member organizations Swabhimaan (trust) and InterAide (French NGO with Indian operations) provide technical and financial support to UpLift. InterAide channels support from various international organizations including the French mutual insurer MACIF that allows Uplift to offer a broad mutual health protection services.

Activities Overview

Through its flagship programme, UpLift Mutuals, the UpLift team seeks to make health care accessible to families in the unorganized sector in India. These families are made up of daily wage earners with a daily income of US$ 2 to 6. They generally have no access to social protection schemes. Given their low income, health is not a prime concern for families until a destabilizing event happens. This can lead to further poverty as they borrow or sell assets to pay for health costs.

The programme provides healthcare, including preventive and promotive services. A major part of its operations involves providing interactive client education and health awareness tools and services for NGOs to help them provide sustainable development services. Its microinsurance project is pioneering a completely community-owned health financing programme in India, and has proven successful as a social enterprise, serving over 100,000 people.

This project aims to expand UpLift?s outreach in two ways:

- Introducing a new savings-financed health product to attract clients without microfinance loans
- Automating its back-office functions (especially claims processing) to improve efficiency and make it easier to replicate its programs with new partners and expand to new locations

UpLift originally offered a health insurance product that is bundled with credit and therefore only available to borrowers. UpLift believed that it could attract more clients by allowing families to finance their premiums through savings. UpLift?s experience shows that families have very low capacity to pay an annual premium up front (without loans), and therefore plans to allow families to finance their premiums and repay them over time. To implement the product, the project includes creating an information system that can manage monthly savings once the back office is automated. By reaching out to potential customers beyond those affiliated with UpLift?s microcredit partners, UpLift believes that it will be able to expand the programme?s outreach to over 250,000 lives.

The project also supported the development of information systems and back-office processes to improve efficiency and allow UpLift to manage a larger volume of claims through greater use of automation.

Beneficiaries

UpLift?s target population are families in the unorganized sector of India. These families (average four members) comprise of daily wage earners and have a daily income of US$2-6. The families generally have no access to social protection schemes. Given the low income, health is not a prime concern for families until a destabilizing event happens which can lead to further poverty as they borrow or sell assets to pay for the health costs. For these families, timely access to quality care at reasonable prices remains a dream. The project will focus on slum dwellers in Pune and Mumbai, and in a few locations in the states of Rajasthan and Tamil Nadu.

Learning Agenda

- Do savings offer a better financing option for health insurance for low-income families?
- How do the costs for communication and enrolment differ across different member organisations?
- What impact does the mutual model bring in a savings financed insurance product?
- What is the impact and effectiveness of technology in a mutual model, especially in reducing costs and efficiently settling claims?
- Does a savings based insurance programme lead to improvement in customer retention and renewals?

Latest Updates

Key Performance Indicators

	PEDO Federations (no. of policies)			PremSeva (no. of policies)
	MADA	Genji	Jhontri	
Year 1	955	879	241	1076
Year 2	1779	837	829	2033
Year 3	Total of 3 federations 4200 policies			2147

Project Updates

As of December 2012

The savings-linked product

Legal status as a cooperative or self-help group is needed in order to take savings in India. UpLift had been unable to register as a cooperative, so it decided to form partnerships with cooperative organizations to distribute its savings-linked product. The following criteria were used for selection:

- Legal status to collect and handle savings and strong financial transaction experience
- Standard and formalized front-end and back-end procedures with strong accounting skills
- Strong community governance
- Readiness to focus on health services
- Interest of the organization in providing the product

UpLift partnered with PEDO, in rural Rajasthan, and with Prem Seva Cooperative Mumbai. The feasibility study on the partnership with Prem Seva was delayed, due to mistakes in the first round of data collection. As a result, an external surveyor had to be used for a second round of data collection.

Within PEDO, there are 3 participating federations ? MADA, Genji and Jhontri ? with separate membership. The same product is offered to all, though buying behaviours have varied between the federations.

UpLift designed the products and finalized them with both organizations and provided training on them. This took longer than anticipated. Although senior managers in the organization fully supported the project, it was more difficult to secure the buy in of the field staff who were focused on credit operations and had no experience of either health or insurance operations.

Before designing and launching the products, surveys were carried out to check the members? interest in saving for their health needs. The results were positive and encouraged Uplift to work with these organizations for the product and process development.

The final products are outlined below:

PEDO final product ? Family floater

Premium: 120 Indian rupees (IDR) per person per year (IDR 600 per year for a family of five)

Maximum sum insured: IDR 12,000 per year, divided into three categories according to disease type and a separate category for cataracts

Savings component: For the first year the current savings are used for paying premiums. The focus is on motivating members to save in order to be able to pay premiums. The renewal contribution will also be taken from the savings account in subsequent years.

Prem Seva final Product- Family floater

Premium: IDR 400 for a single person or couple per year, IDR 750 for a family (irrespective of the number of members, provided they are all living under the same roof)

Maximum sum insured: IDR 15,000 per year, divided into five categories, with a separate category for cataracts

Savings component: Premiums are collected from the savings. Members are motivated to save for the cost of renewal through monthly savings.

UpLift designed a standard set of standard procedures to introduce the products into the field, including client education, enrolment, premium collection, receipts, and so on. However, training staff on these took considerable time as the existing microcredit teams were used, and they had little knowledge on health care. In addition, the client education tools were revised and changed several times, causing delays in the field.

The enrolment process was further delayed as PEDO did not finalize the salaries of the field staff for this extra work. The federation staff therefore did not start enrolments, and UpLift had to intervene and ask PEDO to confirm the salary. Further problems were created by a delay in appointing an operations manager to monitor the field staff and provide support and guidance.

An intense two-month client education programme was carried out before the product launch in both partner organizations. This was carried out through the partners? networks of community representatives.

UpLift also supported PEDO in organizing four promotional health camps before the product launch. A total of 482 members benefitted from these camps.

UpLift established a network of healthcare providers in the area by interviewing staff of the partner organizations to find out which hospitals their members prefer. Ten healthcare signed a formal memorandum of understanding with UpLift and became part of the network.

At this point 2,425 policies had been issued, exceeding the target of 2,000 policies for the pilot.

As of March 2014

Uplift continued to work with the federations and the organizations in aligning processes to customers? requirements, explaining details of the product, and networking relevant hospitals. As time for renewals drew near, it decided to conduct a focused renewals campaign, using demonstration cases of people who had received claims, featuring network hospitals and the advantages of going to them, and providing explanations of how the savings over the year can be used to pay the premiums. Information was shared with all members, even those who had not subscribed in the first year, to help build confidence in the product among all members.

The customer education plan was modified for use by the local community members, which also helped to build trust. Furthermore, health care visits and promotions were linked with self-help group meetings, allowing better communication with all members in one location.

Local federations? involvement was enhanced by standardizing claims procedures and on-the-ground processes, supported by information brochures. This enabled local federations to carry out initial claims verifications and reduced the need for clients to repeatedly go to the hospitals to collect documentation.

The ability to pay the premium from the savings account, in combination with all the process modifications and continuing consumer education efforts, resulted in healthy renewals and new members enrolling in the programme.

Continuing with the work in the subsequent year, Uplift observed that the additional services offered, in addition to the claims paid out during the year proved to be a major attraction for new enrolments as well as people wanting to continue their insurance cover into the next year. Enrolments in PEDO grew from 2,075 to 3,445 and in the next year to 4,200, while Premseva policies doubled from 1,075 in the first year to 2,147 now. Renewals in both areas have been encouraging, with renewal rates in excess of 70% overall, and 96% in one federation.

Development of the management information system (MIS)

Potential vendors were reviewed, and UpLift decided to work with Tieto, a Finnish IT company with offices in India. Tieto agreed to develop a web-based MIS with UpLift, which will be called UpLift Tieto Total Automation for Mutuals (UTTAM). It was important to develop a customized MIS, as pre-designed software does not have the flexibility to cope with the different needs of the potential variety of future partners. Design and development of the MIS begun, but some parts of the work were delayed. Specifications for an improved claims process were developed and coded in the system.

UpLift and Tieto developed a simple excel format for enrolment data, in which the members? information can be easily encoded .This tool is then used to import the data in the software and create the policies.

Trials were carried out, and policies and ID cards were successfully made with the new software. UpLift printed and submitted 1,349 ID cards to PEDO federations. These ID cards have the member information, policy information, helpline information, space to record the health facilities used, and details of the health care provider.

These ID cards are used by members when they use the services and health care facilities of the network heath care providers.

UpLift also worked on making its helpline more widely used. It improved its technical capacity to handle calls, and encouraged greater use among its members, particularly for claims. One partner (Prem Seva) even made calls to the helpline mandatory for claims payout. Stickers were also distributed to remind members of the helpline number. UpLift is monitoring the helpline to see whether there is any change in the pattern of calls.

As of March 2014

Uplift and TIETO continued to work towards further testing and debugging of UTTAM for the automation features. UTTAM was introduced in a few partner locations along with UpLift?s current MIS to check data accuracy. User manuals and a training plan for UTTAM users were developed and field executives were trained in the systems features and requirements.

As of October 2014

Uplift continued with field trials of the UTTAM and training of on field personnel to improve implementation and turnaround times. Some of the process changes and the results achieved are:

- Claim declaration and opening through the software can now be done from the field.
- The courier process has now been bypassed as the claim documents can be uploaded directly in the software from the field office itself.
- Once a claim is opened in Uttam, the auto adjudication system completes the primary checking of the policy status, including policy ongoing or not, number of renewal, claimant covered or not, balance sum insured, claimant history, pre-existing illness, previous claim, and so on, before the claim is passed on to the claim validator for the next stage. This validation previously required checking by an encoder and rechecking by the validator and would take 10- 15 minutes per claim.
- The claim validator can now check the claim papers online. He does not have to remember the policy details of every organisation as the system directly gives information on the sum insured, the balance sum insured, applicable exclusions, claim category limit and the percentage of reimbursement according to the type of hospital used.
- The entire data is encoded in the system and it is possible to extract all the data in the form of report. This has saved a lot of double encoding.
- The claim decision tool is no longer prepared manually and comes from the system directly, saving an entire day of manual work**.**
- The new claim adjudication system has reduced time per claim plus it allows the reduction of the manual errors by the encoder or the claim validator as the system carries out a thorough check.
- At one of the partner organisation in which the new system has been piloted, the turnaround time was reduced to as low as 2 hours, compared to 5 to 6 days in the past.

Uplift continued in its attempt to register as a multistate cooperative, despite significant challenges in doing so. In the mean time, in order to extend the reach of the savings based products, Uplift targeted more organizations that have the capacity to collect savings from members as partners. Uplift would potentially be working with three more partner organisations in 2015 (Antyoday-Pune, Social Action and Implementation (SAI) Mumbai, and Nav Nirman Samaj Vikas Kendra (NSVK) Mumbai).

Uplift shared technical know-how of setting up savings-financed health mutuals within a given time period (3-5 years). Once achieved, Uplift would share only core services with the partner organisation. The launch of the web based Management Information System - UTTAM had already made such a transfer of knowhow and back-end operations possible.

Ulift tested sending information through SMS messages under the IVR system. It found that the phones of members did not have the capacity to read SMS messages in regional languages. In addition, the IVR system had to be integrated to UTTAM for it to be able to answer policy claim related questions, which was expected to happenin 2015.

As of June 2017

Based on the experience with the project and working closely with International Cooperative and Mutual Insurance Federation (ICMIF), Uplift has successfully transferred all the projects to our respective partners and embarked on creating a centralised pool that will be held by Uplift. This will imply focus on expansion of mutually based insurance programmes in defined locations. A programme in Mumbai has also been launched.

Lessons

On product design

Feedback from the partner organization and the community should be used to adapt the product. UpLift?s partners told UpLift that it was difficult to communicate the complexity of the product to the rural tribal community. They encouraged UpLift to reduce the number of categories of illnesses, and to make the contribution system as simple as possible. UpLift therefore reduced the number of categories for the product targeting this community from five to three and attempted to keep the contribution system simple.

Where the population migrates frequently, this must be factored into product design. Many members of the communities served by the product are away from their families for much of the year to migrate for employment. Therefore, after suggestions from the partners, the product was adapted to include hospitalizations outside of the target population area.

Value added services as a part of product design can help increase enrolments. While implementing the programme at PEDO, Uplift experienced a surge in enrolments when health checkups were introduced. The average monthly new enrolments before the introduction of primary care facilities was 55 policies, which increased to 173 policies once the services were introduced.

On distribution

An exposure visit is an important part of training existing teams on microinsurance. UpLift found that the field staff, who were only familiar with microcredit, had negligible understanding of insurance and healthcare. UpLift decided to set aside traditional classroom training for staff, and carried out participatory hands-on training. This also allowed UpLift to see if planned processes for the field staff were likely to work in practice. Exposure visits to the healthcare providers or to similar projects proved particularly motivating for the staff, and helped to resolve practical problems.

Timing and clarity is important to maintain the full support of field staff. It is essential all staff required for implementation of the new project are hired well before the product is launched in the field. Financial aspects such as salary and incentives should be clearly communicated in advance to the field staff. Delay in processing salaries can lead to distrust within the teams. If the field teams are demotivated this impacts directly on enrolment and the health services.

On client education

The local knowledge of field staff is vital to ensure that client education is appropriate for the intended audience. UpLift had to redesign its client education to take into account language barriers and low literacy. It had been communicated to UpLift by the management staff that all members would understand Hindi so the tools were designed in Hindi. When these tools were tested with the field staff they suggested that many PEDO members only understood their local language. The tools therefore had to be redesigned to include translated text and increased use of pictures and dialogue. The story was also redesigned to feature a health crisis that was more familiar to members of the community.

On partnerships

Separate effort is needed to gain buy in from partners? field staff as well as senior management. The project was delayed because UpLift underestimated the time it would take to gain the buy-in of the field staff once it had secured the support of managers. Training may take considerably longer than expected if the field staff have not yet been convinced of the product. It is important for the partner to support interaction with its field staff, since coordination can be very challenging.

On setting up a network of health care providers

It is not possible to manage relationships with health care providers purely remotely. Local representatives should be appointed before the programme starts to build relationships with the providers.

It was not possible for UpLift staff to travel frequently to the PEDO projectarea, so it was necessary to appoint a local UpLift representative to follow up with healthcare providers in person. However there were delays in appointing this role, and this made it difficult to build rapport with the healthcare providers and delayed the signing of the memorandum of understanding.

Hospitals may be able to provide useful support in client education, such as conducting health camps, but they must be willing to come to members? villages. Although hospitals contacted by UpLift were happy to conduct health camps, they wanted to conduct them on their own premises. It was difficult for members to travel from their villages to the hospital for a health camp, and UpLift had to negotiate with the hospitals to conduct the camps in the villages.

On developing efficient back-office systems and automated processes

The input of IT experts is needed to verify requirements and outputs. When the database structure was reviewed by IT experts, it was found that it was not designed in a way that it could handle increased numbers or product complexity. The system therefore had to be reworked at this stage, causing delays. In the end UpLift hired a dedicated IT professional to facilitate the process. Ideally, UpLift should have planned for IT experts to have validated the system from the beginning.

The MIS system must be sufficiently flexible to account for a range of partners? requirements. UpLift found that it was important to develop a customized MIS, as pre-designed software did not have the flexibility to cope with the different needs of the potential variety of future partners. Its partnership with a trusted organization has helped UpLift to get a design closer to expectations. A vendor approach would have meant that iterations would not have been possible, and would have been very costly. Part of the cost of building the MIS is being born by the partner organization (TIETO), without which it would be difficult to build a customized solution.

Web-based processes have reduced processing times. In the new web based MIS (UTTAM) the claim documents can be uploaded from anywhere and can be checked by the underwriter from anywhere. This has enabled Uplift to we have been able to reduce the average turnaround time from 45 days to 10 days at two locations where filed trials have been conducted. Claims meeting process have also been modified whereby all claims falling under the stipulated criterion are not sent for claim committee discussions but are passed through the system. The web nature of the claims meeting (a separate module created for the meeting purposes) allows communities to conduct meetings online and take the decisions using the system. This feature currently under field trials is expected to give mutual governance and claims TAT further push.

The new system also allows the transfer of the Federations? data in excel to the new web-based MIS. This has reduced earlier issues regarding double entry of data (once on the field and then at the central office). Furthermore, ID cards can now be printed from the system at the local federations? offices, whereas they were previously printed centrally at Uplift, with photos attached manually, and were then distributed by post. The new process has halved the time taken for enrolment (a reduction of 3 days).

This will also hopefully lead to a reduction in costs and have an impact on IEC processes. This will continue to be evaluated as the system becomes fully functional.

At one of the partner organisation in which the new system has been piloted, the turnaround time was reduced to as low as 2 hours, compared to 5 to 6 days in the past. There is reduction in terms of costs too. Initially Uplift required 5 encoders to do the work now it has been reduced to 2 encoders.

On access to health insurance

Savings-based schemes can allow the poorest and most vulnerable people to access healthcare. The members of the three federations working with PEDO are tribal families and almost all have official cards to show that they come into the ?below the poverty line? category, meaning that they are from the poorest economic strata. Members of the cooperative in Mumbai are slum dwellers and their capacity to pay is slightly higher than the PEDO Federations but still very low.

The data shows that 95 per cent of households covered under the scheme have women as policyholders. The decision to start such a product in their respective federations and cooperative organisation has been voted for by women. Their decision to save separately for health instead of using their current savings is indicative that women are willing to save and take steps to ensure their and their families? health. However, whether they have a higher tendency to save than men will only become clearer after a few years of operation of the scheme.

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