Learning Journey

Swayam Shikshan Prayog (SSP)

Enhancing community resilience in low income households in India (Building a Community Health Fund)

Contents

Project Basics

About the project

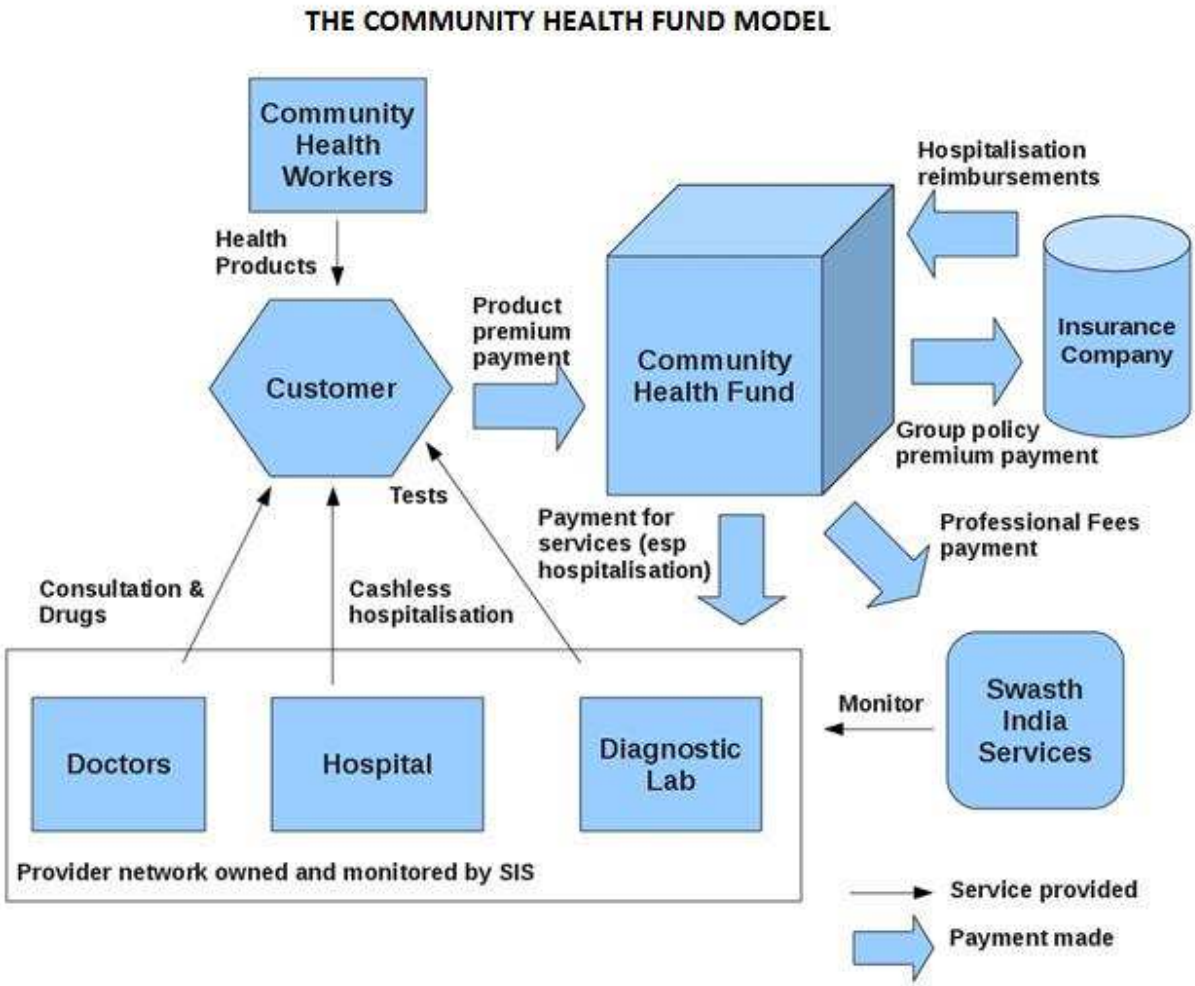
The mission of **Swayam Shikshan Prayog ('SSP')** is to build resilience in low income households in rural India by improving access to healthcare services and insurance and creating an economic safety net through grassroots women's collectives.

SSP has partnered with Swasth India Services ('SIS') to pilot a Community Health Fund (CHF) in which a comprehensive health product has been offered. The project envisaged implementation of a health insurance product (inpatient care insured and cashless delivery) with an out-patient component delivered through a network of Community Health Workers (CHWs), physicians, diagnostic centers and drug dispensing units, coordinated by a Community Health Trust. The overall objective of the project is to provide insurance benefits which: 1) are easily understood and adopted by the end consumers, without most of the inherent complexities of current products in the market (such as exclusions, sub-limits on expenses, waiting periods, etc); 2) provide a fallback mechanism during catastrophic health events; 3) reduce the costs of smaller but more frequent health expenses.

Key aspects of the project include:

- Member families will pool voluntary savings to create a self- sustaining CHF.
    1. The total premium will be collected by the CHF from the members.
    2. To secure the CHF from high claims, the CHF will procure a group insurance policy from a regular insurance company, using a part of the premium collected
    3. Remaining part of the premium will be retained by the CHF for self-insurance and running the scheme's operations, including the outpatient component
- A hybrid health insurance model will be developed to test its ability to provide:
    1. Insulation from health events with high out of pocket costs through a group insurance policy and cashless facility for hospital services (up to an annual cover of US$667 for the whole family)
    2. Additional value to clients from reduction of 30 per cent in healthcare costs – by providing them access to 50 per cent discount on consultation fees from a network of local physicians and 40-70 per cent discount on the retail price of drugs
    3. Reduction in disease incidence through quality primary and preventive services
    4. Quality assurance in health-services delivery through regular quality audits of providers and customer feedback surveys
- The CHF will forge partnerships across the health value chain – with insurers, hospitals, doctors, diagnostic labs and pharmacies - and focus on acceptability, affordability and quality and build a robust, low-cost and low-overhead comprehensive health system.
- A network of CHWs will be developed to be front line servicing staff for the CHF, to promote better health and to develop as grass roots social entrepreneurs.

- In the first two year phase of the project, the product will be rolled out in 100 villages in two districts in the state of Maharashtra with a total population of 250,000 – 300,000 people.



Project Summary

Project Name:	Enhancing community resilience in low income household in India (Building a community health fund)
Project Start Date:	July 2009
Duration:	30 months (extended to 3 years, ending January 2012)
Country:	India
Product:	Health

Project Updates

Key Indicators

Date of pilot launch: October 1st, 2009

Coverage Indicator	Oct 2009	Jan 2010	July 2010	May 2011
Number of policies	NA	413	1,192	2,201
Number of covered lives	NA	1,723	5,055	9,133
Growth Rate	NA	NA	NA	NA
Coverage Ratio	NA	1%	2.2%	7-9%
Renewal Rate	NA	NA	NA	~25%
Percent policies BPL	NA	44%	44%	~52%

Client Service Indicators	Oct 2009	Jan 2010	July 2010	May 2011
Time to create a policy	NA	30	30	30
Number of claims settled – cashless	NA	6	117	697
Number of claims settled – reimbursement	NA	2	NA	40
Number of claims rejected – cashless	NA	NA	22.5% by insurer & 2.5% by CHF	15.5% by insurer & 2.1 % by CHF
Number of claims rejected- reimbursement	NA	0	2	NA
Days to pay out of network claims	NA	NA	60	NA
Per cent Out Of Pocket cost	NA	14%	NA	36%

Health Indicators	Oct 2009	Jan 2010	July 2010	May 2011
Claims incidence ratio	NA	3.2%	7.5%	8.90%
Claims frequency by age category	NA	Not evaluated	Not evaluated	Not evaluated
Length of Stay (days)	NA	3.8	3.8	4.6
Average claim amount	NA	90 USD	108 USD	96 USD
Number of members with OPD visit/year	NA	106	715	6,026
Number of non-members with OPD visit/year	NA	418	463	Not evaluated
Average pharmacy cost pmpy	NA	0.91 USD	0.58 USD	0.6 USD
Average savings OPD	NA	0.40 USD	0.47 USD	0.8 USD

Financial	Oct 2009	Jan 2010	July 2010	May 2011
Earned premium	NA	0.40 USD	4,175 USD	53,332 USD
Net Income Ratio	NA	Not evaluated	- 660%	Not evaluated
Incurred Expense Ratio	NA	Not evaluated	217.9%	Not evaluated
Claim ratio (from insurer partner for hospitalization policy)	NA	102%	206%	118% (settled claims only)
Claim ratio CHF	NA	Not evaluated	248%	141%
Value of rejected claims	NA	Not evaluated	5,174 USD	pending
Operating Expense, CHF (per life)	NA	Not evaluated	4.78 USD	Not evaluated
Pharmacy distribution expense (per life)	NA	Not evaluated	1.62 USD	Not evaluated
Total Rx value	NA	US$483	908 USD	US$ 7,860
Total Savings for members	NA	US$44	457 USD	US$ 10,481

What is happening?

As of August 2009 (Project kick-off)

In 2007 Self Help Groups (SHGs) in India were demanding health insurance to deal with shocks. SSP undertook a pilot project to promote health awareness, to test a community-based hospitalization scheme, and to train Community Health Workers (CHWs). The main role of CHWs was to promote health policies which promised clients up to US$200 of reimbursement for hospitalization. The money was pooled to form a totally self-insured Mutual Health Fund with a total member base of about 4,500 lives. However, clients requested outpatient financing solutions.

- In April of 2009 CHW roles were expanded. In addition to enrolling people into the program, they began to take basic health information, conduct preliminary diagnosis through a kit and sell a few common medications. Improvements to the earlier model included procuring a group policy with a commercial insurer (to reduce financial risk to the fund), forming a panel of doctors who provided 50 per cent discount on consultations and simulating a cashless hospitalization process (i.e. clients did not have to finance hospital care up front, then submit a claim for reimbursement). The hospitalization benefit was enhanced to an annual cover of US$667 for a family. To improve customer service and prevent moral hazard, a "network facilitator" was appointed who visited the patient at the hospital during admission and discharge.
- In October 2009 a CHF Trust, and governance structure was formed. A plan was devised to offer the insurance product in 100 villages, using one CHW per village to sell and service the product. Although a continuous enrolment was initially planned, after taking into account the potential for adverse selection or delayed enrolment for those with a "wait and watch" outlook, a defined enrolment period was piloted. The planned model for pharmacy was to place community pharmacy in villages, but due to licensing challenges, a "physician-office" pharmacy model was piloted. Based on prior experience, it was felt that two different price points for the

health product would be feasible, and a source of cross subsidy to benefit lower income clients. Thus, a more affordable option ("Silver") costing US$13 and a more expensive product costing US$22, with richer benefits ("Gold"), was offered. INR 450 (US$10) was the portion of the member fee that was transferred to the insurer, The Oriental Insurance Company (Oriental), for the hospitalization policy (a subsidy of INR 300 was available from the government for Below Poverty Line (BPL) families). Without much data on willingness to pay, the project team needed to see how these first products would be received. Community data revealed a high seasonality of income due to the agricultural economy. September 2009 – April 2010 was believed to be the best period for enrolment and premium collection, taking into account timing of income and also outflows of discretionary money (for festival and marriage seasons).

As of October 2009

The initial plan to launch in 100 villages was determined to be overly optimistic and too large for piloting. Instead, a phased roll out was implemented, with 40 villages in October and another 80 in February 2010. The additional 20 villages (120 in total) provided a buffer against drop-outs or poor uptake. Based on challenges to recruit, train and retain CHWs, a revised plan was implemented that split - (i) sales of policies and (ii) servicing of healthcare delivery. Dedicated sales people focused on sales, while the CHW focused on community mobilization, awareness, health promotion, and after sales servicing. Compensation and incentive mechanisms required further development and calibration.

An initial hospital and physician network (three facilities and seven doctors) were contracted. A drug-distribution center was set up to procure low-cost drugs from manufacturers, stock inventory and distribute it to the physician network. A web-based IT system was also tested, which enabled both the field-staff and the central team to capture customer registration data, generate photo-identity cards, track hospitalization and outpatient cases, capture drug sales data and generate MIS reports.

Since October 2009, the sales model has undergone many changes. For Phase 1, the implementation team adopted a two-tiered structure with one Sales Agent appointed for every five villages whose role was to fill up registration forms, collect money and deposit it in the central office. A Health Coordinator was identified in every village to spread awareness about the product and mobilise prospective customers for follow up meetings with Sales Agents.

As of December 2009

The implementation team decided to split the roll out into three phases instead of 2. Phase 2 included 40 villages in January 2010, and phase 3 was planned to include the final 40 villages in February 2010. A primary reason for this further phasing of the roll out was to experiment with outsourcing of policy sales for one of the geographies to a sister concern of SSP, using an incentive based compensation system in lieu of fixed monthly professional fees. This organization already had a sales force on the ground retailing multiple products (such as cooking stoves, water filters, rechargeable lamps, etc) and the team believed that, if successful, this model would reduce the fixed costs of maintaining a dedicated sales

force. Pre-existing conditions and maternity benefits were now excluded from the hospitalization cover (they were not excluded from the initial product design). Early experience with the pharmacy distribution showed a demand for a smaller than expected set of "common" drugs (around 40 versus 100-200 initially planned). It appeared that the drugs provided were at a 30-70 per cent discount from maximum retail price (MRP) to clients. Non-clients could also purchase these drugs at a 10 per cent discount from MRP. A gender bias emerged in staffing:

- Male candidates for sales agents were hard to find, perhaps due to other employment opportunities. Thus only women were recruited.
- Only women pharmacy sales agents were recruited due to the belief that they are more trustworthy and hence, there would be little or no leakage of drugs stocked at the doctors' offices.

As of January 2010

The product was launched in the second batch of 40 villages. Initial uptake was lower than expected, so enrolment was offered continuously and the team monitored for adverse selection. Additional steps were taken, such as conducting promotional events at village markets where there is an inflow of people from the surrounding 10-15 villages, forming enrolment teams who would spend 2-3 days in a village promoting the product and registering customers and offering a discount for immediate enrolment after a campaign. While the cost of customer acquisition went up, the enrolment figures also increased by more than three-fold.

Refinements to the product continued. For example, exclusion of all pre-existing conditions was determined to be difficult to identify and enforce, so this exclusion was relaxed and limited to just two procedures where early data showed potential for abuse - hysterectomy and surgery for kidney stones. Maternity benefits continued to be excluded for the first year. During enrolment, the sales staff reported challenges to obtain the necessary documents and to obtain photos for all family members. Clients or prospective clients mentioned that a one year waiting period for maternity was not desirable, and the definition of a family to be up to five persons was an unwelcome limit for some with larger families.

The implementation team observed some challenges with the physician office based pharmacy model. After some time, the team could understand better that those doctors who dispense drugs which provide a significant source of income are reluctant to modify their prescribing or pricing patterns. This challenge was felt to be a key factor in four of seven contracted doctors dropping out of the

network. SSP also observed over-prescribing and a lack of standard prices and documentation by doctors. As learnt later, a key reason for such behaviour was that the initial participating doctors were approached with a commercial proposal, and not a social one which would have been better aligned with their interest to participate in the network.

With respect to sales and servicing, there was some turnover of the CHW staff in part due to the delay of the roll out (no income, lost interest), or dissatisfaction with compensation. A commission sharing arrangement emerged where Sales Agents shared half of the earned commissions with CHW and/or SHG leaders who facilitated the village level sales. SSP further refined its sales approach based on whether a village has a doctor present. In villages with doctors, CHWs focused more on "activation" to encourage clients to visit the doctor for appropriate care. Finally, the effectiveness of the sister organization of SSP to whom a part of the sales were outsourced was also tested. Sales staff reported community members had difficulty to pay the full premium, and requested to allow installments. This was pursued through SHGs.

As of July 2010

The product was now launched in more than 150 villages, versus the originally planned number of 120. This happened because there was significant consumer demand in the adjoining villages, leading to the Sales Agents enrolling members in these villages. As long as there were no additional operational requirements (like more staffing, expansion of provider network, additional travel expenses), the implementation team did not envisage any issue with this arrangement. The hospital network now comprised ten facilities. Approximately 1200 policies were sold, covering 5000 lives. Overwhelmingly, clients preferred the cheaper Silver product, accounting for 98 per cent of all enrolment. The premium for Silver was increased from INR 650 to INR 750 (US$16.70). The product experienced a bias in enrolment of male children (70 per cent of total children enrolled), possibly due to the limit of five persons per policy and the decision of some families to preferentially insure boys over girls. Households defined as Below Poverty Line (BPL) comprised 44 per cent of the CHF enrolment, despite already being eligible for comparable hospitalization benefits for a small annual fee of INR 30 (ca. US$0.70) through a national health insurance scheme sponsored by the Government of India, called Rashtriya Swastya Bima Yojana (RSBY).

Due to the challenges of working with local doctors with varying preferences, multiple pharmacy models emerged. In some places, completely SSP-owned pharmacies and clinics were set up. In others, tie-ups were made with existing pharmacies. There were stringent regulatory requirements, however, for these models, in addition to limited availability of licensed chemists and both high costs for capital and operating expenses. Hence, the preferred model still continued to be that designed initially – that of a doctor who stocks drugs and dispenses them to the consumers, post consultation. Some of these doctors prefer to buy the drugs upfront, while others do not want to carry the risk of inventory. For the latter, drug sales agents are deployed at their premises.

Some cash flow challenges arose because Raksha, the third party administrator (TPA) of the insurer (Oriental Insurance Company Ltd), was scrutinizing claims more thoroughly, and requested more justification. SSP monitored and tried to determine the best ways to manage the claim turn around, which is currently 60 days or more, well above the limit of seven days enforced by Raksha.

As of February 2011

Results for the CHF as of January 2011 were generally well below target, and presented a difficult challenge to the project team. Only 2,600 policies had been sold, with approximately 2,100 active at that time, covering approximately 10,000 lives (30,000 lives had been targeted). Two hundred ten (210) villages as opposed to the planned number of 120 were included in the enrolment area based on requests to include families in neighboring villages. Enrolment for the total villages represented amounted to only a three per cent penetration. Sixty two per cent of members were clustered in 30 villages, 20 per cent of members resided in the next group of 30 villages, and the final 18 per cent were dispersed in 150 villages.

Policy renewals had started with 16 per cent of policies coming due as of this time. Though the actual number of cases to be renewed was still fairly low, the initial renewal rate was 27 per cent versus a target of 60 per cent. Further, the incidence of hospitalization among clients was 11 per cent, more than double the benchmark of four per cent that had been expected. It was found that approximately 40 per cent of hospitalizations were due to highly preventable common water-borne diseases that could have been treated in an outpatient setting. The higher rate of hospitalizations contributed to a claims ratio in excess of 300 per cent and an expense ratio of 136 per cent. Though higher than desired, these ratios were not unexpected for this early stage of project development.

The provider network now comprised of nine hospitals plus discounted outpatient services at four clinics owned by the CHF Trust together with nine contracted clinics (scaled back from the originally planned number of 25). Only about half of the total enrolled members had access to the discounted outpatient services, and for most of these members, the discounted outpatient consultations and drugs were on offer for only a short time. As a result, visits for outpatient services were only 0.2 visits per member per year compared with an expected level of one outpatient visit per member per year.

Where discounted outpatient services were accessible, SSP noted that 89 per cent of 450 households surveyed were satisfied with the CHF as the discounts allowed them to save an average amount equivalent to approximately 40 per cent or INR 300 (US$6.67) of the premium paid for the CHF scheme.

The villages with the highest level of promotional effort showed higher penetration (11 to 12 per cent versus three per cent overall). Additionally, central to a key learning objective of the project, SSP observed that villages with access to discounted outpatient services reported a lower hospitalization incidence (7 per cent) compared to hospitalization rates of 14 per cent in villages without access to outpatient services. This could suggest that an indirect benefit of outpatient services may be to reduce inpatient utilization. With respect to renewals, again though early days, SSP observed that clients who had experienced discounted outpatient services available through the CHF were three times more likely to renew their membership.

The sales and health promotion staffing model now included 15 CHWs who, after a three month intensive training, focused on health education and basic treatment. The CHWs were trained for 3 months on preventive health measures and to provide health services rather than enrolment. A five percent commission of INR 35 (US$0.75) per enrolled family proved to be insufficient and after some CHWs dropped out, and the CHW activity was stopped entirely. A team of approximately 75 Sakhis (sales assistants), took responsibility for health promotion, sales and enrolment with a commission of ten per cent of premium.

Problems in submitting claims to the insurer through its third party administrator persisted. As of February 2011, of 329 claims submitted, some 60 per cent were rejected due to failure to submit the claim within the stipulated seven day limit, which was unrealistic for small rural providers.

The CHF experienced a cash flow squeeze, which forced it to delay payments to some hospitals beyond the 30 day maximum turnaround time that it had promised. Overall, this challenge required significant staff resources to analyze and try to resolve, and frayed relations with hospital partners. In February 2011, Oriental agreed to re-process pending claims. The team began to work through the backlog. The frequency of claim rejections during this period for other reasons (e.g. eight per cent for ineligibility) have been acceptable, and the preauthorization and adjudication processes managed by SIS were working smoothly.

During the last half of 2010, SSP experimented further with the outpatient services delivery model, ending up with two ongoing models:

1. Self-owned clinics with drug inventory supplied by SIS: Only two of the 25 self-owned pharmacies remained in operation. The two clinics offered discounts to patients of approximately 40 per cent. The clinics provided control of provider treatment and dispensing behaviours, but also had high fixed costs. This model could be viable in more densely populated town centers, where visits could be high enough to cover the high cost structure.
2. Rural "cash and carry" model: Nine village based doctors, who were less established and therefore more willing to comply with a discounting approach, were enlisted. The doctors were willing to use a generic based drug formulary operating under contract to the CHF Trust. Doctors purchased low cost drugs from SIS at discounts of approximately 25 per cent of MRP and in turn dispensed the drugs at a lower than average cost to CHF members. The viability of this model is sensitive to the volume of both CHF members and non-members (who pay non-discounted fees).

By May 2011, the program was focused in 70 villages where there was high potential and the response was evident on the benefits of the program. The hospital network was retained at ten multi-specialty and specialty hospitals and the OPD network spanned ten clinics including three CHF Trust owned clinics. Generic drugs were centrally procured and stocked at the warehouse in Solapur and distributed through OPD clinics on cash and carry basis. The well established CHF Trust supervisors took on larger roles in promotion and lead generation while the Sakhis completed enrolment process with the community members.

In February 2011, with the support of the Facility, an in-depth evaluation of the performance of the CHF and underlying drivers of results was undertaken. The evaluation allowed the project team to further analyse and reflect on lessons learned to date, and to review and refine next steps to optimise the performance of the CHF and to work toward a sustainable future. Accordingly, the action plans were revised from April 2011.

As of June 2011

In response to the challenges experienced with claims and learning more about preferences of the targeted population, a wide range of strategies were used to promote insurance and educate families on how to be healthier through preventive measures such as better nutrition and hygiene. These programs included a newsletter, published with the endorsement of hospital and physician leaders or other opinion leaders, which featured the benefits of the CHF product and highlighted client experiences which were positive. Member sensitization camps were held for more than 1600 persons, and further community support was evidenced by a local radio sponsorship. SSP had organized a mobile skit to emphasize the key messages that included ownership of the CHF by a local community Trust that was operating a low cost, transparent program for the benefit of the community. The SSP arranged for live testimonials from satisfied clients to be delivered in over 50 villages. Enrollment was observed to grow where potential clients could hear testimonials from neighbors who had accessed hospital services and had a positive experience. Overall, it appeared that word-of-mouth was an effective and necessary

promotion strategy, without which the deep rooted beliefs about insurance and medical care being poor value could not be overcome.

By 1st June 2011, the SSP switched from a cashless to reimbursement approach for claims. This was due to increased scrutiny of claims by Rashka, the third party administrator, and resultant delays in settlement of claims and to reduce working capital requirements for CHF Trust to advance payments to hospitals before receiving reimbursement from the insurer. This also reduced the financial risk borne by the CHF Trust for any claims denials. SSP observed the average cost per claim falling by approximately 20-30 per cent. Simultaneously SSP decided to temporarily stop enrolment from June 1st for three to four months coinciding with the monsoon and agriculture season.

All active policyholders were informed by letter and signed an agreement that from 1st June 2011, they were responsible for payments to the hospitals in case of hospitalization and would receive reimbursement from the CHF Trust within one month of submitting an approved claim. Similarly, a letter was issued to all hospitals by the CHF Trust informing them that patients would pay all bills directly to the hospital.

SIS had been contracted at the inception of the project to operate the community pharmacies, the outpatient clinic and inpatient hospital network and to oversee project management and information systems support. The greater geographic focus in fewer villages resulted in lower utilisation of drugs, forcing the closure of the SIS operated stocking point (warehouse) in May 2011. Similarly, the switch from a cashless to a reimbursement policy for claims and the pause in enrolment resulted in a much reduced role for SIS. As of June 2011, SIS transferred all the network facilitation roles, project management and liaison with insurer and its TPA to the CHF Trust/SSP field teams.

Renewed efforts were made from May 2011 by SSP to reduce the time for hospitals to fulfill documentation requirements for claims submission. The turnaround time to obtain a complete hospital bill was reduced from 60 days to 15 days, a significant improvement but still short of the seven days stipulated by the insurer. SSP established direct contact with the TPA. In June 2011, SIS provided SSP training on claim data entry, submission and online tracking. Oriental was informed of the claims experience, in particular the deterioration of the claim ratio, for the scheme.

Project Lessons

On client value from a comprehensive health insurance product (satisfaction and impact)

Attractive rates can be negotiated with hospitals, if approached with the broader social objectives. The larger hospitals are more compliant to agreed processes than smaller ones. Hospitals have offered rates which are about 20-25 per cent lower than those offered to other clients – both individual patients and insurance companies. They not only respect these rates but also offer 15-20 per cent discount on the final bill, if further negotiated. Large hospitals (having 50–200 beds) provide sufficient documentation (detailed case-history of patients, line-item billing, etc.) and are receptive to queries, even if it means that payments may get delayed. Smaller hospitals (having a 20-40 beds), however, do not provide sufficient documentation and are less tolerant of payment delays due to unresolved queries.

Outpatient doctors are more amenable to work in the program, if approached with the broader social objective. Pharmaceutical companies provide strong incentives to the doctors to prescribe their brands. Nonetheless, an appropriate incentive can still be designed. If the proposal to the doctors is purely commercial, then they expect financial incentives. Doctors generally want to create goodwill in the community they work with. Linking up with a community health program (provided minimum commercial interests are protected) is a good way to improve their image. It has been found that doctors will give a discount of 15-30 per cent on consultation if they are included in the programme. This discount can be as much as 50 per cent if doctors are paid a fixed monthly capitation fee of US$20. The doctors are also willing to conduct health camps also – which serve the dual purpose of promoting the health scheme as well promoting individual doctors.

The introduction and increasing awareness and acceptance of subsidized programs like RSBY may impact interest of BPL families to enroll in private health insurance programs like the CHF. Low income people may be willing to pay for a comprehensive product with outpatient savings and perceived quality even if a free (or nearly free) option for hospitalization is available, based on early findings that more than 40 per cent of CHF clients were BPL. The team believes that this is due to the perceived value of the outpatient discounts, lack of trust in the government programs and access to additional private hospitals not in RBSY's network that are more trusted. A subsidized program like RSBY may present challenges for a private health insurance programme due to a need to differentiate the benefits clearly, and because clients may choose the subsidized program. SSP plans to learn more

about the needs and interests of its BPL clients, including their perceptions and use of RSBY, and their reasons for enrolling in the CHF.

Low income clients need to see greater benefits with or be able to afford higher priced product options. SSP differentiated its Silver and Gold options as follows:

1. There is a per hospitalization limit of US$222 for Silver, but not for Gold. The policy maximum is US$667 in a year
2. Differential pricing developed for BPL and APL populations:
    1. Silver: Family of 5: US$13 for APL ; US$7 for BPL
    2. Gold: Family of 5: US$22 for APL ; US$16 for BPL
3. Outpatient: same access to discounted care for both product versions

Initial uptake showed an overwhelming preference for Silver, suggesting that the perceived additional value of Gold is not sufficient to warrant the higher premium, or that clients simply cannot afford the higher premium.

Other observations related to in-patient services are as follows:

- Proximity to network doctors (and their being established in the community) was observed to positively influence uptake due to more convenient access and greater trust.
- Hub cities have hospital costs that are comparable to those in urban centers. With few options, this threatens the ability to achieve sustainable claim ratios given these hospitals' higher rates and greater use of diagnostic tests, both of which lead to higher claim costs. To illustrate, the average charges at the highest cost hospital were INR 5300 compared to average charges of INR 2300 at the least costly hospital.
- Smaller, rural hospitals may deliver better financial value but struggle to properly document medical records and provide adequate billing details timely.
- Intravenous drips appear to be a common service provided that may be subject to over-use, adding costs to frequent cases of gastrointestinal illness. Clients may demand such "care", and doctors can increase their revenue by delivering these services, which "can't hurt".
- Clients appear to be willing to travel for better (real or perceived) inpatient services, based on admission patterns occurring.
- There is demand for maternity cover (currently excluded in year one). Clients do not value maternity cover which begins in year two. SSP plans to explore alternative financing options such as pre-payment and/or credit to help clients fund maternity costs. SSP does not feel it can manage adverse selection if the waiting period for maternity would be eliminated.
- SSP has learned that it is difficult to identify and exclude pre-existing conditions. Procedures that appear to be over-utilised (such as hysterectomy and kidney stone removal) have a mandatory waiting period of one year.
- There has been significant increase in the rate of hospital admissions from May 2010 – July 2010, primarily because of an creasing awareness amongst clients after seeing others receiving

the benefit, moral hazard by hospitals and patients through conversion of outpatient events to inpatient events, and the onset of the monsoon season itself – leading to the higher incidence of water-borne diseases.

Access to outpatient services can increase renewals in a health insurance scheme. Clients who did not use either outpatient or inpatient services had a 15 per cent renewal rate compared to a 44 per cent renewal rate for those who used outpatient services, and a 50 per cent renewal for those who used both outpatient and inpatient services. Where discounted services were accessible, clients surveyed reported an 89 per cent satisfaction rate.

Clients did not utilize the discounted outpatient services as frequently as expected. Outpatient visits occurred 20 per cent less frequently than expected. Only 46 per cent of families who could have used the discounts for outpatient care used them at all, whereas those families who did access outpatient services did so at the rate of 1.8 visits per person per year (8 per family per year). The results suggest that where services offered were constant and families had a previous relationship, the usage was much higher.

2. Willingness to pay

Seasonality influences WTP and enrolment, particularly in rural, agricultural and undiversified economies. There is a need to consider harvest time (income received) and festivals (spending of disposable income).

A simple definition of a Family (who can enroll under a policy) can create unanticipated bias. A family larger than the permitted number of lives (currently defined as a family of five) may selectively exclude girls (at least 70 per cent of children enrolled thus far are boys, whose health is more valued than that of girls).

The 'average premium per life' is US$2.40 (with the breakup being – US$ 3.00 for APL and US$ 1.60 for BPL). From June 2010 onwards, the premium was increased by 15 per cent and yet, the monthly enrolment numbers remained the same – thus indicating that willingness to pay may hover around these levels for a comprehensive health-scheme.

Client education needs investment and targeted messaging. Insurance is sold, not bought. Despite the conviction of the implementation team, the target market does not immediately understand the CHF product and recognize its value proposition. SSP had to battle a deep rooted belief amongst rural communities that insurance companies don't pay, and hospitals don't take care of the rural poor.

Communication materials need to be simple, and focus on how insurance can help (as opposed to terms and conditions of a policy).

"Word of mouth" (testimonials) is an effective strategy to spread the word on insurance. Targeted messaging through print and visual media was not considered to be as effective in persuading the target population to enroll in comparison to a word of mouth strategy. SSP extensively used local media inputs, and "road show" campaigns in all project villages (over 200 villages). This was accompanied by intensive community level meetings with women's groups and opinion leaders. At these meetings, existing CHF members shared their experiences. Rural communities relied much more on the experience and word of mouth from their peers and neighbors and CHWs before deciding to enroll. This was confirmed by SSP's experience in outreach and sales in other sectors such as clean and green energy products.

3. Other

Cashless claims may encourage moral hazard by both clients and healthcare providers. Clients had cited the cashless mechanism as one of the three most important factors for enrolling in the CHF. It was observed that cashless claims were higher than claims paid under a reimbursement mechanism. Clients may have realized they could seek hospitalization "for free" (and avoid a less expensive but out of pocket cost for an outpatient visit). At the same time, hospitals may have realized that payments from the insurer could be counted on, and there could be less scrutiny onsite of the charges, or what was being done. This is borne out by the fact that the average cost per claim fell by 20-30 per cent shortly after the reimbursement model was implemented, likely due to greater community and client engagement. Further, SSP has had no client complaints, evidence that client engagement in paying for hospital services is accepted by clients as a necessary part of the process.

A flexible policy toward defining a service area may lead to adverse selection. Given the desire to encourage enrolment, SSP decided to revert to an open, continuous enrolment. Within less than one year of launch, SSP had enrolment in 210 villages, which stretched the implementation team's resources and may have encouraged adverse selection. A more complete analysis of claims and health seeking behavior is needed to confirm whether and to what extend this may have occurred. Other factors such

as the availability of cashless benefits and the presence of a CHW may have also influenced interest to join the scheme, and to use it once enrolled.

Preventable illnesses are significant drivers of claims costs, and must be controlled, for the scheme to achieve financial viability. SSP observed that at least 40 per cent of its claims were for waterborne illness that could be avoided or treated earlier through better health prevention or earlier treatment in outpatient clinics. Success in reducing preventable illnesses is a cross-cutting issue related to sanitation, education, government effectiveness, etc. and often requires a long term intervention horizon. It may be that such efforts are more successful in villages where the interventions are made at the village level (e.g., improving water sanitation).

A low premium health insurance product must control the utilization of high cost facilities. SSP has experienced this challenge. It is considering implementing some form of member cost sharing when using more expensive hospitals to deter the natural tendency to choose higher cost facilities. SSP believes this could be coupled with more promotion of the benefits of local (and lower cost) healthcare providers in the network.

A low premium health insurance product must control unnecessary utilization of services. Select procedures subject to inappropriate utilization, like intravenous hydration and kidney stone removal in the case of SSP, should be identified and interventions instituted where utilization or costs may be excessive.

Access to outpatient services may reduce inpatient hospitalization. Clients with access to outpatient services had a seven per cent hospitalization incidence rate compared to 11 per cent for those who did not.

On effectiveness of Community Health Workers as entrepreneurs

1. Efficiency of CHW to service clients

It can be difficult to impossible to find local staff in a low income, rural community with the skills to do both sales and health promotion. It was in fact very difficult to develop a cadre of CHWs, and the role as initially envisioned was dropped in a short time. SSP learned the importance of testing and adapting based on experience the selection, training, compensation and incentives to deploy CHWs. For example, it became clear that it's most efficient and more effective to train CHWs in groups, as they learn from each other. CHWs were most effective in health promotion and education.

SSP discovered that, based on skills of CHW trainees, it was more effective to create dual roles between CHWs and Sales Agents (it was difficult to find the full range of needed skills in one person). When active, CHWs focused on health promotion activities only, leaving the responsibility for sales to dedicated Sales Agents (one agent supported around 5-10 villages). There was a village-level Health Coordinator whose main role was to create awareness about the product and mobilise people for the Sales Agent to convince. An open question which remains was whether over time, the Health Coordinator could be merged with the CHWs (through training and skill upgrading of the Health Coordinators) as the program developed more maturity in training and monitoring of the CHWs.

2. Level of satisfaction in role

A social mission can be more motivating than financial rewards to recruit and retain CHWs. Contrary to early perception, SSP found that CHWs have larger attrition if they are given a financial incentive to be part of the program. Anything below US$10-15 per month was not considered financially attractive and this amount cannot be sustained by the program. Hence, recruitment of CHWs shifted to only those women who view their role as predominantly socially oriented, with no expectation of remuneration other than from the sales of health products. While the recruitment exercise becomes prolonged and intense, the end result was more positive – the CHWs were truly motivated about their role and the health-related activities assigned to them.

3. CHW turnover

Training of field health and insurance promoters is more successful when done in iterative, ongoing sessions. SSP found that some CHW candidates had poor attendance, and the quality of learning was lower when an intensive, residential training was enforced. Instead, the training was found to be more effective when it was staggered. For example, a batch of CHWs was trained over a period of six months – with "day-long training sessions" spread over two to three days each month. All the CHWs were trained on basic examination and diagnosis of basic ailments, and to conduct timely referrals and/or provide appropriate medication. This training was more successful when CHWs were given additional support through practical onsite work after each training module.

Recognition and certification are valuable elements for CHW retention. Continuous support and motivation created an enabling environment for the CHWs. It was found that the CHWs take the program more seriously when they are made to undergo a mandatory certification examination after the training. A launch function was held in every village to introduce CHWs and refresher training sessions were conducted every month when the CHW role was active.

It is difficult to train community women to sell and service insurance. A viable CHW programme requires well designed, tested and refined components (recruitment, training, incentives, building of an image in the community, etc.). Despite learning many lessons on these various aspects of a CHW programme and continuously improving the model, by early 2011, SSP had concluded that the CHW role as initially envisioned was too resource intensive to be sustained by the CHF, at least in the short to mid-term. In the future, a community based model of volunteers who receive small incentives to promote health (as opposed to promote insurance) is envisioned, whereas sales will be handled by trained supervisory staff.

On the feasibility of a low-cost drug supply chain

1. Revenue potential for retail drug sales

It can be challenging to set up an independent community pharmacy. SSP experienced significant challenges to get permits for a community pharmacy. In the Indian environment, each pharmacy needs to have full-time B.Pharm (Bachelor of Pharmaceuticals) license-holder; these professionals are very scarce. Real estate near a high traffic point (typically the market area or the bus stand) which customers prefer is also expensive. Moreover, the time taken to get certification from the Food & Drugs Administration usually

stretches beyond two to three months and is often accompanied by the expectation of bribes expected by corrupt bureaucrats.

A successful drug supply chain may require more than one pharmacy delivery model. It is believed that it is not possible to arrive at one single drugs model which will work across all locations and yet be able to provide 30-70 per cent discount on retail prices to the consumers. Doctors have different viewpoints about stocking drugs (primarily due to the risk of carrying inventory).

In 2010, five different models were tested, the last two of which were felt to be viable for further development and possible scaling:

- Drug sales agent model (discontinued): Some doctors are unwilling to take the risk of drugs inventory and bear the administrative hassle of dispensing the drugs. For them, a drug sales agent can sell drugs on an as needed basis at their premises. The drugs are owned by the program and doctor gets paid a fixed fee. This model was unsuccessful due to limited success in recruiting willing doctors as flat fees for the dispensing of drugs was not readily accepted, and doctors were reluctant to reduce revenues from the drugs they dispensed. It was also difficult to create a cost effective drug sales agent and distribution system to serve "mom and pop" clinics. It was also expensive to source the drug sales agent.
- Pharmacy as partner model (discontinued): The idea of this model is that doctor convinces a nearby pharmacy to buy drugs from the program, in order to dispense to our consumers at a discount. Here also, no fees are required to be paid to the doctor. Few pharmacies were interested in participating.
- Owned pharmacy model (discontinued): Challenges included high set up costs, licensing requirements and finding licensed chemists.
- Cash and carry model: Doctors buy drugs on a "cash & carry" model and the entire risk of drugs inventory is transferred onto them. They don't require any assistant at their premises and neither do they require any fees. This was a simpler model to implement and was more readily accepted by some doctors.
- Owned clinic model: The clinic operates with a full-time salaried doctor at the premises who can prescribe drugs. This model is costly to set up and relies on some level of volume to succeed, hence is viewed to be more viable in a higher population area. It also gives greatest control over delivery of care (quality and cost control advantages).

Several models were tried and various factors influenced the models: whether the doctor dispenses or prescribes, population density, doctor acceptance of the drugs made available to prescribe, etc. SIS was able to procure a range of common drugs at an average discount of 40 per cent, the majority of which could be passed on to clients. Long term viability of the owned clinics with pharmacies or the cash and carry model still needs to be demonstrated, but this model shows promise to address a critical element of client demand and out of pocket expenditure.

2. Business and social proposition to create a network of outpatient providers

Doctors resist the increased use of lower cost drugs, if approached with a commercial proposal. Doctors rely on greater margins and incentives from pharmaceutical suppliers to enhance their revenue, and they may perceive brand name drugs to be more effective. If approached with a commercial proposal, they want similar incentives because the program is perceived as "profit making". Therefore, doctors need to understand the social benefit of being part of a community health program. To protect their minimum financial requirements and to ensure that they significantly reduce their fees, a fixed monthly compensation may be provided.

Doctors who are less established in their communities may be more willing to partner with insurance schemes. SSP noticed that established physicians, who may be older, are less open to new approaches to deliver medical care. Physicians with greater interest to grow their practices were easier to recruit and work with under a low cost drug prescription model.

3. Benefits to consumers of access to lower cost drugs

Patients may resist a change in a prescription to a lower cost alternative, so it's important to overcome their perception that cheaper drugs may be inferior. It's difficult for clients to understand the relative value of a smaller discount on a lower priced drug versus a larger discount on a higher priced drug which in fact is costlier. Moreover, consumers are circumspect about "switching drugs" – i.e. procuring a brand different from that prescribed by their physician. Therefore, there is a need for an option of stocking and dispensing drugs through a network of local physicians who already have a good reputation. In India, doctors are legally allowed to retail drugs. This translates into a "win-win" model for all – the network's outpatient doctors have more footfalls and customers have high trust in the efficacy of the drugs dispensed.

On Project Management

It's easy to underestimate the complexity of a project and resources required, or to anticipate where the bottlenecks will occur, or fully anticipate impact of challenges in one facet of the project on others. Ample time and budget also needs to be provisioned for recruitment and training of operations staff. All processes, even with the introduction of IT systems, need to have a backup manual process also defined – in order to take care of power-cuts and internet outages. Period review meetings are very important to keep the accountability of staff sufficiently high. Measurable targets must be assigned to all staff in these meetings, depending on their respective roles. Due to the large number of financial transactions occurring in the system, it is critical to appoint a dedicated accountant for tracking the money. A monthly review meeting at the top-most level, like a Steering Committee meeting, is a must in order to make sure that the programs broad goals are being adhered to.

Smaller scale pilots can allow more efficient testing of ideas. As noted above, the project quickly expanded its geographic coverage, which strained the implementation team resources and resulted in low penetration, and made raising awareness more daunting. Most likely, fine-tuning the product and

enrolment processes would have been easier and cheaper to do under more limited, controlled conditions.

Capacity building for a community-run health insurance scheme is important. SSP identified that its community member based Board of Trustees that oversaw the CHF would have benefited from more extensive capacity building. Essential skills include monitoring the CHF's key performance indicators such as claim ratio, and understanding how to respond when corrections are needed, as well as developing and managing a plan to achieve sustainability. The Board also would like to strengthen the audit and cash handling controls to ensure proper management of CHF funds.

A health insurance scheme must keep close control of claims with an insurer. Under a cashless system, the CHF was funding hospital claims on behalf of its members, and relying on the hospital to bill timely and accurately, and for the insurer to then pay promptly. SSP learned of a bottleneck between its project management team and the insurer and its third party administrator in which claims were getting rejected without timely identification or resolution of the problem. This led to a cash flow problem followed by a labour-intensive process to re-submit claims in hopes of getting reimbursed. The reconciliation of nearly 500 rejected claims is now underway as of July 2011.

Next Actions

Based on the evaluation results, along with considerable challenges encountered with low enrollment and an unacceptably high claim ratio, new enrolment in the CHF was temporarily stopped as of 1 June 2011 to allow SSP to focus on a transition from the present model to one that it believes can promote greater sustainability of the CHF.

In terms of next steps:

- The CHF will focus operations in fewer villages (50) and implement interventions (e.g. more focused grassroots insurance education) to increase penetration through higher enrolment and renewals. SSP believes it can scale up to 70 villages in three years and capture 100,000 members.
- Enrolment will be limited to two low illness periods in the year (e.g. avoid monsoon season) to reduce adverse selection and improve administrative efficiency.
- Ten trained Community Health Volunteers will work with communities to reduce water borne illness and promote basic hygiene and nutrition, in an effort to reduce hospitalizations and claims costs.
- Community governance of the CHF will be strengthened through the CHF Board of Trustees, e.g. by including healthcare providers as advisors. Additionally, community-based Health Governance Groups will be formed to enable greater participation by community members in the oversight of the CHF, and to engage directly with the healthcare provider network to create more visibility and accountability for performance.
- The Government of Maharashtra has launched Rajiv Gandhi Jeevandayee Arogya Yojana (RGSJAY) and Solapur has been selected for a pilot. If the RGSJAY scheme rolls out, SSP could leverage its community experience across multiple districts to facilitate and monitor this scheme.
- Though in first stages of conceptualization, SSP will consider options for a savings mechanism within the communities to help minimize the burden to clients of having to finance the hospital care until reimbursement is made by the insurer.
- The Trust overseeing the CHF will take over direct relationships through its Board, selected advisors and a network of community-based groups to run all facets of the CHF, including setting up and maintaining a contracted healthcare provider network, interfacing with the TPA and insurer, and managing claims and operations. The next step is to resolve a pending backlog of rejected claims to obtain greater claims settlement for legitimate claims, and build a closer working relationship for the future.
- A more robust monitoring and reporting system will be built for claims management and cash handling.
- The discounted pharmacy supply chain will cease.
- The premium will be increased from INR 750 (US$16.70) to INR 860 (US$18.90).

Although it is clear that the initial projections to scale up were overly optimistic and significant progress must be made to address high claims and low enrolment, the rich lessons learned should contribute to further progress toward meeting the objectives of the project. SSP will continue to refine these and other plans with an aim to achieve a sustainable program in approximately five years.