Learning Journey

VimoSEWA

Bringing “Health” into Health Insurance: Evidence for a Converged Approach

This Learning Journey was created with contributions from Sapna Desai (VimoSEWA) and Jeanna Holtz (the Facility)

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Project Basics

About the project

The Self Employed Women’s Association (SEWA) is an Indian trade union registered in 1972 which today has over 1.3 million members in nine states of India. SEWA members are poor women workers in the informal economy, including agricultural labourers, service providers, home-based workers, and vendors. Since 1992, SEWA has offered a composite insurance product (life, hospitalization, accident, and asset insurance) known as VimoSEWA (meaning SEWA insurance) for members and their families in India.

VimoSEWA’s experience confirms a high demand by clients for protection against the costs of prevention and treatment of illness. Over 90 per cent of VimoSEWA’s claims are for illness. More specifically, the data indicate that at least one third of these claims result from preventable acute illnesses such as malaria, gastroenteritis, and water-borne diseases that, if treated early on, should not require hospitalization. Unnecessary hospitalization results in loss of income and assets for the poor and negatively affects health. Furthermore, fewer hospitalizations can improve the viability of insurance by reducing claims expenses.

VimoSEWA believes that preventive health information, access to immediate treatment, and outpatient health care services can reduce the number of patients hospitalized for common illnesses, resulting in savings for families who otherwise incur avoidable out of pocket expenses, as well as for the insurance programme. The project aims to test if implementing targeted community health education and referral for common illnesses has an effect on insurance claims, health-related expenditure, and health-seeking behaviour.

The project was implemented in three stages. In the first phase, VimoSEWA reviewed health claims in Ahmedabad city and district, in order to identify patterns that may influence health-seeking behaviour and incidence of primary illness. Data reviewed included geographic location, population demographics, average cost of illness, and choice of healthcare provider. In addition, a baseline survey of insured households was conducted. VimoSEWA sought to gain insight into healthcare preferences, and how they vary depending on the illness and at which point in the continuum of an illness that insurance is utilized.

In the second phase, VimoSEWA developed specific health interventions to target common illnesses. The interventions included community-based group health education, a doorstep primary service by community health workers (CHWs), links with outpatient services, provision of herbal medicines, and referral to government services. Finally, during phase three, the effectiveness of the interventions was tested. A sample of 1,960 households from two wards of Ahmedabad city and two areas of Ahmedabad...
district were studied. Control groups of insured and non-insured households received SEWA’s ongoing health services, but no targeted information or special educational materials for common illnesses that were targeted as part of the study.

At the end of the study, statistical analyses of the claims database, household surveys, and interviews with claimants and non-claimants provided information on the impact of health education delivered by community health workers on both the insured and uninsured, as well as how insurance affects health-seeking behaviour. Results from the study will be used to inform VimoSEWA’s approach in all programme areas in Gujarat and the six other states of India. Project leaders believe that the results will have implications for health insurance providers who serve poor households throughout the world.

<table>
<thead>
<tr>
<th>Project Summary</th>
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<tbody>
<tr>
<td><strong>Project Name:</strong> Bringing “Health” into Health Insurance: Evidence for a Converged Approach</td>
</tr>
<tr>
<td><strong>Project Start Date:</strong> December 2008</td>
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<tr>
<td><strong>Duration:</strong> 4 years, ending December 2012</td>
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<tr>
<td><strong>Country:</strong> India</td>
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<tr>
<td><strong>Product:</strong> Health</td>
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Project Updates

Key Performance Indicators

The following are 2010-2012 figures for the health benefits under VimoSEWA’s composite insurance product:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polices</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall VimoSEWA</td>
<td>101,397</td>
<td>99,117</td>
<td>79,824</td>
</tr>
<tr>
<td>Ahmedabad City</td>
<td>27,627</td>
<td>44,510</td>
<td>45,999</td>
</tr>
<tr>
<td>Ahmedabad District</td>
<td>7,097</td>
<td>9,632</td>
<td>9,543</td>
</tr>
<tr>
<td>Claims ratio</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall VimoSEWA</td>
<td>103%</td>
<td>105%</td>
<td>161%</td>
</tr>
<tr>
<td>Ahmedabad City</td>
<td>94%</td>
<td>140%</td>
<td>172%</td>
</tr>
<tr>
<td>Ahmedabad District</td>
<td>120%</td>
<td>99%</td>
<td>136%</td>
</tr>
<tr>
<td>Renewal ratio</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall VimoSEWA</td>
<td>65.8%</td>
<td>64%</td>
<td>59%</td>
</tr>
<tr>
<td>Ahmedabad City</td>
<td>79.64%</td>
<td>82%</td>
<td>73%</td>
</tr>
<tr>
<td>Ahmedabad District</td>
<td>61.06%</td>
<td>59%</td>
<td>57%</td>
</tr>
<tr>
<td>Rejection ratio</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall VimoSEWA</td>
<td>13.33%</td>
<td>16%</td>
<td>13%</td>
</tr>
<tr>
<td>Ahmedabad City</td>
<td>15.53%</td>
<td>17%</td>
<td>13%</td>
</tr>
<tr>
<td>Ahmedabad District</td>
<td>15.52%</td>
<td>13%</td>
<td>10%</td>
</tr>
</tbody>
</table>

What is happening?

As of February 2010

Research Design

The project was designed as a cluster randomised trial. Treatment and control clusters were chosen among the population using statistically robust techniques, creating a sample of 1,960 households (in 28 clusters) to test the effect of the interventions on both insured and uninsured households.

Sampling the uninsured populated presented a number of challenges. During the project design phase, VimoSEWA expected to use government census data, which was not always be available. With no accurate maps or censuses for slums or rural villages, researchers armed with an area house listing had to systematically follow a health worker through the study areas to document each uninsured household she would potentially work with. While the challenges in identifying the control group
resulted in a delay, they also provided a number of lessons for individuals conducting research in urban slums.

**Household survey**

The household survey was planned for five rounds over the two year project to track illness and health-seeking behaviour. Health workers and researchers developed and tested the survey tools over several months. Client surveys underwent at least five revisions, in which modifications were made to questions and language. The final tools reflect VimoSEWA’s grassroots experience on which types of questions elicit accurate responses, rather than standard health survey formats. In addition, the surveys were designed to capture the entire range of treatment-seeking behaviour over a 2 year period, rather than the more commonly used method of one-time recall.

SEWA Academy, the research agency partner, trained a team of 16 surveyors in December 2009. Following the training, the baseline survey was initiated in January 2010, about two months later than anticipated due to the additional time needed to finalize the research design. During the initial survey, researchers encountered a number of problems including locating households without an exact address, finding survey times that were convenient for women, and locating workers in the informal economy who migrate for employment.

**Health Intervention**

The health intervention consisted of group health education sessions with women by SEWA’s trained local community health workers (CHWs) on the most claimed-for illnesses (waterborne illness and malaria/fever), and the most common treatment (hysterectomy). Fourteen CHWs implemented the intervention in Ahmedabad city and district. The intervention consisted of the following:

1. **Group education sessions** on diarrhoea, malaria, and hysterectomy, with groups of 10-15 women conducted 3-5 times a month by each CHW in her work area. In addition, Mahila SEWA Housing Trust, a SEWA sister agency that specializes in housing and sanitation, conducts group sessions on sanitation infrastructure with intervention area CHW groups.

2. **Communication aides** for the education sessions were developed by an advertising agency:
   (i) Two tailor-made ‘snakes and ladders’ participatory games on diarrhoea and malaria
(ii) A 15-minute film on hysterectomy with case studies from SEWA members, Illustrations, interviews with local gynaecologists, and information on potential side effects
(iii) Posters and flip charts with illustrated diagrams
(iv) Take-home illustrated pamphlets for participants

3. Community media: Community wall paintings on prevention and treatment of diarrhoea and malaria.

4. Monthly refresher training: Conducted for CHWs on the specific health education topics and general health communication techniques.

The intervention is an add-on to SEWA’s existing programme:

**CHW activities in control and intervention areas**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Control</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home visits</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Accompanied referral</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Medicine sales</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Linkages with government providers</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Activate Village Health Committees</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Group education sessions by CHWs</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Communication tools/handouts</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Wall paintings in community</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Monthly refresher training</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Sanitation education</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Communication aides were developed to be relevant and interesting for participants. Various media, e.g. wall paintings or posters, group education aides (flip charts, games, and films), and individual handouts (leaflets and samples) were created in partnership with an advertising agency. The communication messages for each session were developed with the health worker team, based on existing evidence in public health literature and the team’s suggestions on feasibility, local acceptability, and perceived effectiveness. The 14 CHWs were broken into three small groups for workshops to decide, with inputs and review from a physician and external experts, 1) how to identify the illness 2) treatment options and 3) prevention messages for communication material for waterborne disease, malaria/fever, and hysterectomy.

The implementation team participated in two training sessions. The first training focused on designing the treatment and communication protocols for three common illnesses: waterborne illness, malaria, and fever. The second training, which was conducted by a senior gynaecologist from New Delhi’s largest public hospital, focused on appropriate use of hysterectomy, which occurs at a much higher frequency and at a lower average age than medically indicated. The trainings will continue on a monthly and then quarterly basis.

As of July 2011

Health prevention and promotion interventions

In April 2010, the 14 CHWs held their first education sessions prior to the start of the monsoon season, the high season for waterborne disease. The first part of the intervention period therefore focused on water borne disease and malaria. The hysterectomy sessions were postponed allowing CHWs to focus on one topic during their first few months as trainers. In the initial three to four months, implementation was refined, with additional trainings and practical support provided as required. There have been, on average, 42 health sessions per month (with 20-25 women per session) since the start of the intervention. They will continue at the same frequency until May 2012. As the quality of the health education sessions is a critical component of the project, VimoSEWA ensures that health workers attend regular, ongoing trainings and monthly meetings to review issues and education techniques, and improve message delivery.

To improve consistency, guidelines for the education sessions were developed following observation of ten meetings (six urban and four rural):

1. Each education meeting should cover only one of the three topics.
2. CHWs are to inform the members in the community about the session in advance.
3. The CHWs should start a game as soon as four to five members arrive. By the time all the women arrive, the game should be over and the CHW can begin the discussion using posters.
4. The CHWs should focus on key messages during the meeting and have members repeat the messages at the end of each session.
5. To ensure that meeting participants memorize the key messages, each participant should repeat the messages before taking the soap given out at the end of the training.
6. If the education topic is diarrhoea, the CHW should do a practical demonstration of preparing oral rehydration salts (ORS). The demonstration involves boiling water, cooling it, measuring the correct amount using the measuring cup that was given to each CHW and mixing ORS powder. The CHW should remember to carry a packet of ORS.

The guidelines were discussed during regular monthly meetings to review issues and share best practices.

**Action research implementation**

From February 2009 to March 2010, the baseline study design went through several iterations, pilot testing, and feasibility analyses. The survey was completed in March 2010 and successfully reached 1,934 households out of the planned 1,960 households. If a household could not be located, the reason was carefully documented. The researchers have prepared a detailed process description, which will be used as part of a process evaluation paper at the end of the project. A second-round survey was conducted six months after the intervention began (November 2010), and a midline survey was initiated in June 2011. Further, qualitative research was conducted to understand what influences treatment-seeking behaviour and women’s responses to the intervention.

**Preliminary analysis of baseline data**

The baseline data cover 11,287 individuals in 1,934 households. The data were entered into a database by SEWA Academy over two months and presented to VimoSEWA in August 2010. Data cleaning was completed after three rounds of internal consistency checks in October and November 2010. Next, descriptive statistics of the baseline study were generated and shared with the VimoSEWA and SEWA Health teams in January 2011. Baseline findings included:

- 47 per cent of households reported an illness in the last month, with primary illness (e.g. fever, diarrhoea, and malaria) most commonly reported.
- The proportion of households who reported hospitalization in the past six months was higher for rural than urban households, and higher for insured versus non-insured families (i.e., rural: 18.6 per cent for insured, 12.3 per cent for uninsured; urban: 14.6 per cent for insured, 10.5 per cent for uninsured)
- Private hospitals accounted for 62 per cent of all rural hospital admissions compared with 45 per cent for urban admissions
- Hysterectomy was the most common reason women were admitted to hospital (exceeding deliveries), and occurred more frequently with rural women. In fact, 9.8 per cent of rural women surveyed had had a hysterectomy, with nearly one third being performed on women younger than 35 years of age.

**Publications and supporting documents**

Recently, VimoSEWA published a more detailed paper in *Reproductive Health Matters* on the prevalence and implications of hysterectomy, among rural and urban women with and without insurance in Gujarat.
At least three more paper topics have been identified including women’s health-seeking behaviour in Gujarat, the impact of insurance status on health care utilization and survey design issues.

Links to documents on the baseline study:

- Presentation/overview
- Survey instrument

As of January 2013

Further baseline analysis
VimoSEWA conducted further statistical analysis on the baseline survey to compare morbidity, outpatient treatment-seeking, and hospitalization patterns amongst insured and uninsured adult women. Controlling for the limited demographic differences that emerged, it found that morbidity and outpatient treatment-seeking are similar – yet insured women are significantly more likely to be hospitalised. The illnesses that led to hospitalization were not confined to common illness or hysterectomy: the insured are more likely to be insured across all health conditions.

This analysis is one of few that examine illness patterns of treatment-seeking behaviour when comparing the insured and uninsured. The conclusion is that, while VimoSEWA’s insurance increases utilization of inpatient health services, the implications are mixed for the health system. While insurance may fulfil unmet demand, it may also compensate for poor quality outpatient care that in turn leads to unnecessary hospitalization. The linked qualitative research explores this question further. VimoSEWA recommends integration of a health perspective into evaluations of community-based health insurance, to explore if increased hospitalization improves health outcomes.

Qualitative research
Two qualitative research studies were initiated and conducted from November 2011 to March 2012. Although not initially planned for in the project proposal, the baseline findings raised two important questions that SEWA wanted to explore further: 1) Why are insured women in urban Ahmedabad hospitalised for common illnesses such as fever and diarrhoea? 2) What are the influences on women’s decision to have a hysterectomy?

1) In urban Ahmedabad, fever and diarrhoea were the leading reasons for insured women to be hospitalized, but this was not the case for the uninsured. To better understand these episodes of illness, including women’s perception of their illness and the health care they receive, VimoSEWA conducted qualitative research with women who were recently hospitalized for common illnesses, their families, and local health care providers. The results indicated that women rarely sought hospitalization first – they almost always tried (and spent money on) outpatient care to treat a common illness. Insured women did not appear to seek immediate hospitalization as a substitution for outpatient care because with insurance, they could save out of pocket expenditure. The research highlighted that hospital admission carries considerable opportunity costs for working women who also manage their households, and was chosen only
after outpatient treatment repeatedly failed. In summary, insured women appear to seek hospitalization only as a last-resort to cure a persistent illness.

Health care providers felt insured women would more readily agree to be admitted to hospital, as their insurance would cover all or a portion of their health care expenses. The likelihood that a health care provider would be influenced to act in self-interest (moral hazard) by admitting a patient for care in the hospital in order to collect fees paid by an insurer could not be ruled out, however.

2) The hysterectomy research included 35 women, insured and uninsured, five providers, key informants such as midwives, and local health workers. Gynaecological morbidity, lack of accessible, affordable gynaecological care, a perceived lack of need of the uterus, provider practice, and women’s demand emerged as factors to explore further in understanding what drives hysterectomy amongst women under 45.

Endline survey
An endline household survey was conducted with the same sample of 1,934 households who participated in earlier rounds, with some attrition due to a slum demolition in Ahmedabad city. VimoSEWA is currently conducting in-depth statistical analyses of the cluster randomized trial to ascertain if and how the intervention affected the primary outcomes of illness incidence, treatment-seeking behaviour, hospitalization, expenditure, and claims patterns amongst the insured, as well as compared to the uninsured. Preliminary analysis of secondary outcomes indicates that the CHW intervention resulted in more interaction and higher satisfaction with SEWA’s community health workers in rural areas. SEWA’s education intervention improved some preventive health practices amongst urban households, but not in rural areas. Households in urban intervention areas reported higher use of effective anti-mosquito measures and safer drinking water practices.

Dissemination
Findings from the research have been disseminated through presentations, publications, and sharing workshops. The baseline survey results were shared with VimoSEWA and SEWA Health leadership, field managers, and grassroots workers in three workshops. These led to additional hypotheses and support for the initiation of qualitative research. Two papers have been published in academic journals, and two are currently under review. VimoSEWA has also presented: a mixed methods analysis of hospitalization for common illnesses at the University of Twente conference on microinsurance; baseline and preliminary endline findings at the ILO Microinsurance Facility Health Forum in Delhi; a poster on hysterectomy at the WHO Health Systems conference in Beijing; and an analysis of claims, survey findings, and qualitative research on hospitalization at the Munich Re conference in Dar es Salaam.
Project Lessons

On partnerships for action research*

Close collaboration is needed between the researchers, the implementing organization, and an academic advisor who understands the local context and the realities of the intervention is essential. The academic advisor brings rigour and objectivity, while the project team has access to and credibility among the community. Intense collaboration is necessary to: i) maintain methodological rigour, such as avoiding contamination; ii) avoid resentment towards the research; and iii) enhance researchers’ understanding of the intervention tools. Budgets should be adequate to fund both the quantity and the calibre of human resources required for rigorous research; otherwise research may be compromised or prolonged.

VimoSEWA researchers and their implementing counterparts (i.e. CHWs) benefited from working together to develop systematic processes and standard materials for use in each of the health prevention and promotion interventions. The teams collaborated to effectively deal with small, ongoing challenges which emerged as the interventions were tested. As a result, researchers’ understanding of the intervention tools and processes, seen through the lens of the community, was enhanced. They could analyse data and adapt tools and processes more effectively.

*VimoSEWA defines action research as research that addresses a problem that has emerged from an ongoing programme. Action research has the specific purpose of collecting data and information to strengthen and improve the programme.

In hindsight, VimoSEWA would have allotted more time for design of the research for the project, and to ensure sufficient coordination between an academic, research agency, advertising agency and intervention teams all at once. Rather than the six months preparation time typically required for action research, one year was required to plan a rigorous impact study that involves multiple partners and a grassroots intervention.

On designing action research on preventative health care interventions

It is essential to analyse the frequency and cost of health claims on a consistent and comparable basis to uncover what is really driving trends. For example, instead of focusing on the total number of claims incurred and their aggregate cost, VimoSEWA segmented and analysed several years of claims data on a standard and thus comparable basis (e.g. number of hospitalizations per 1,000 members). By looking at claim incidence, cost and diagnosis per 1,000 members and not only in aggregate (regardless of the number and type of members), trends can be more easily observed, and the “noise” coming from fluctuations in number of members and their characteristics (e.g. age, health status) can be reduced. Comparisons over time, or across products or populations, are easier to make, enabling the HMI scheme to better understand what drives its performance. In addition, this type of analysis of illness patterns allows for comparison with public health data. For more details, see Emerging Insight 10.

Mixed methods research is an effective evaluation and learning tool. A research study and programme evaluation that uses mixed-methods allows for a more meaningful picture of the reasons behind a trend or the effect of an intervention. When the VimoSEWA team found the baseline study findings puzzling, qualitative research provided the insight to understand why adult women were hospitalised for fever
and why hysterectomy is a leading reason for hospitalization. Similarly, qualitative research around the intervention raised more research questions and angles for analysis and interpretation of quantitative data.

**Systematically comparing insured and uninsured populations can be very insightful for a microinsurance programme.** Although the intervention was aimed at insured women, the study surveyed insured and uninsured women. By sampling from the same communities, it was possible to identify differences – and important similarities – in demographic characteristics, morbidity patterns, and health-seeking behaviour between insured and uninsured women through the baseline survey. Although this was not the primary objective of the work, this analysis provided critical insights on the utilisation and product design of VimoSEWA and similar microinsurance programmes, as well as SEWA’s community health programme.

**On carrying out action research on health interventions**

**Careful testing and piloting should be used to adapt methods to local realities.** Surveys, in particular, should be tested thoroughly before household interviews begin. Based on the experience of VimoSEWA, it is critical to test a range of methods to define and measure illness, particularly for minor illnesses. Local individuals who are familiar with the culture and available services should be trained to administer the survey. Innovations in sampling methods and research implementation processes may also be required, such as drawing a sampling universe through following a health worker on her rounds.

**Implementation is a key – and variable – part of an intervention, and must be documented.** Meticulous planning does not mean that an intervention will be implemented smoothly and as intended. While this seems obvious, it is critical to capture variability and gaps in implementation to understand results. For example, VimoSEWA found that CHWs performed differently in implementing a standard health education intervention. To capture this, VimoSEWA introduced spot quality checks mid-way to track recall amongst participants across CHWs. These indicators helped VimoSEWA interpret results, as well as identify training needs during the intervention. VimoSEWA also monitored the interventions by observing and participating in intervention activities to document if, how and why a simple intervention varied. Most importantly, the research and implementation were allowed to inform and influence each other, resulting in modifications and enhancements to both.

**It’s important to have a research coordinator to interface with the implementing team and the researchers.** The project manager found that additional help was needed to ensure adequate coordination between the implementing team and those collecting data for research. The coordinator must check data quality, understand how to interpret ongoing results of the project, and make the adjustments necessary to maintain the rigorous research standards.

**Investment must be made to ensure data quality at the outset.** Hospital claims data require significant time and effort to sort and code to obtain more useful analysis. VimoSEWA realized once it dug into claims data that there is a high degree of inconsistency in how claims are reported. One of the greatest challenges is to group like diagnoses and like procedures together, as they can be documented inconsistently. For example, at least 16 types of fever were documented in the claims data sample using various terms such as fever, acute malaria, viral fever, and so on, making it difficult to create a comprehensive count of admissions due to fever. For more details, see Emerging Insight 12.
In addition, the researchers decided that survey data would be “double-entered”, a research gold standard for data quality. However, VimoSEWA did not anticipate the time and resources needed to properly clean and organize the data and record it twice. While researchers were initially focused on the action-oriented, grassroots elements of the project, the extra investment in sorting and double data entry was considered time well spent to enhance the validity of the results.

**On the findings of the action research**

**Morbidity patterns are a key, yet often overlooked, indicator of the performance of a microinsurance scheme and the health care delivery system.** The illnesses that drive claims shed light on why claims are incurred. Morbidity patterns also inform insurers about the effectiveness of health care delivery, and how clients access care for various illnesses. This information can suggest ways to intervene to improve value for clients and enhance performance and viability of the scheme. Interventions might include, for example, modifications of benefits, or health camps to reduce incidence of a particular illness.

In the case of VimoSEWA, high claims rates for illnesses amenable to outpatient care and hysterectomy at a young age raise questions for product design as well as the need for quality outpatient care. In particular, the findings on hysterectomies, which emerged as a primary driver of claim costs, raise concern about the degree to which hysterectomies are necessary. Possible reasons hysterectomies may be performed when they are not medically necessary are financial motivation of providers, or because the procedure may be viewed as best available alternative to manage a range of reproductive health issues faced by VimoSEWA women. For this reason, VimoSEWA created a specific health intervention to educate women as to when a hysterectomy may be necessary and when it is not. To support this effort, a second opinion feature was implemented to encourage clients to validate with a government physician or a SEWA health worker, supported by an in-house doctor, if a hysterectomy recommended by a provider was supported by medical evidence.

**Epidemiological statistics can help interpret claims data.** Epidemiology is the study of the distribution and determinants of disease. Epidemiological data provide a starting point for expectations regarding the frequency and types of illness that an insured group might experience. This can help guide the design of health interventions or other value-added services, as well as support accurate pricing (based on more accurate prediction of expected claims) and optimal product design. VimoSEWA sees a high rate of hysterectomy in women below the age of 40, yet it is a challenge to interpret this finding (or others like it) without benchmark data on the expected incidence and cause of illnesses, and accompanying guidelines, which can help to establish when it is appropriate to perform procedures like hysterectomy.

**Urban clients have more claims and their cost per claim is higher than that of their rural counterparts.** VimoSEWA observed different health-seeking behaviour in Ahmedabad city compared to the rural district locations. Reasons for this will be analysed further, but hypotheses include: 1) drug use per claim is higher in urban settings; and 2) access to hospitals on a “cashless” basis might encourage hospitalizations, though it’s not known if this creates a positive outcome for clients’ health.

**Drugs are another key driver of claims costs.** In India, government hospitals are free to clients, but due to corruption, leakage, and so on, drugs are often not available and patients must purchase them out of pocket. VimoSEWA’s plan covers drugs as a part of hospitalization, so in fact 50 per cent of all claims costs due to costs of drugs when a client is hospitalized.
Next Actions

VimoSEWA is conducting statistical analyses of the cluster randomised trial, analysing qualitative and quantitative data on hysterectomy and conducting a process valuation of the intervention. Academic and working papers are being prepared on each set of results. They include:

1. ILO Working Paper on hospitalization patterns
2. The effect of a CHW-led health education intervention on women’s health and health-seeking behaviour
3. Process evaluation of a CHW-led health education intervention
4. Mixed methods research paper on hysterectomy in Gujarat
5. Can a health education intervention reduce hysterectomy?
6. ILO Working Paper on the overall study, intervention design, and results with implications for HMI
7. Notes on practitioner led research: learning from a VimoSEWA action research trial

This will also generate further lessons around the cost benefit of investing in health interventions and their impact on health-seeking behaviour, which will be featured in the next update of this Learning Journey.

Future areas of research

Our findings so far have also provoked new questions for investigation by microinsurance providers and researchers. They include:

1. Health care providers: What are provider treatment patterns, motivations, and incentives, and do these differ for insured and uninsured patients? This requires in-depth qualitative research across public and private providers, their interaction with patients, and for specific illnesses.

2. The health impact of health insurance: Given the higher rate of hospitalization by the insured for all illnesses, do they ultimately enjoy better health? The health benefits of investing in microinsurance (and health insurance overall) have not been well researched in developing country settings. This type of longitudinal work could shed light on the links between financial security and health, if increased treatment-seeking indeed improves health, as well as allow a comparison of client satisfaction with actual health outcomes.

3. Outpatient services: Given the VimoSEWA claims pattern and qualitative findings, could quality outpatient care reduce hospitalization for common illnesses? Should such coverage be integrated into inpatient products – and is it financially feasible to do so?