



© ILO, Crozet

PAPER No. 36

MAKING HEALTH MICROINSURANCE WORK

TEN RECOMMENDATIONS
FOR PRACTITIONERS

.....
Jeanna Holtz, Tobias Hoffarth and Caroline Phily

Jeanna Holtz,
Abt Associates, formerly the ILO's Impact Insurance Facility

Tobias Hoffarth,
GIZ, formerly the ILO's Impact Insurance Facility

Caroline Phily
ThinkWell, formerly the ILO's Impact Insurance Facility

Copyright © International Labour Organization 2014 First published 2014

Publications of the International Labour Office enjoy copyright under Protocol 2 of the Universal Copyright Convention. Nevertheless, short excerpts from them may be reproduced without authorization, on condition that the source is indicated. For rights of reproduction or translation, application should be made to ILO Publications (Rights and Permissions), International Labour Office, CH-1211 Geneva 22, Switzerland, or by email: pubdroit@ilo.org. The International Labour Office welcomes such applications.

Libraries, institutions and other users registered with reproduction rights organizations may make copies in accordance with the licences issued to them for this purpose. Visit www.ifro.org to find the reproduction rights organization in your country.

ILO Cataloguing in Publication Data

Making health microinsurance work: Ten recommendations for practitioners

Holtz, J.; Hoffarth, T.; and Phily, C.,

International Labour Office - Geneva: ILO, 2014

34. (paper no.36)

ISBN: 978-92-2-126328-9 (web pdf)

International Labour Office

Key Words - microinsurance / health microinsurance/ synthesis

11.02.3

ILO Cataloguing in Publication Data

The designations employed in ILO publications, which are in conformity with United Nations practice, and the presentation of material therein do not imply the expression of any opinion whatsoever on the part of the International Labour Office concerning the legal status of any country, area or territory or of its authorities, or concerning the delimitation of its frontiers.

The responsibility for opinions expressed in signed articles, studies and other contributions rests solely with their authors, and publication does not constitute an endorsement by the International Labour Office of the opinions expressed in them.

Reference to names of firms and commercial products and processes does not imply their endorsement by the International Labour Office, and any failure to mention a particular firm, commercial product or process is not a sign of disapproval.

ILO publications and electronic products can be obtained through major booksellers or ILO local offices in many countries, or direct from ILO Publications, International Labour Office, CH-1211 Geneva 22, Switzerland. Catalogues or lists of new publications are available free of charge from the above address, or by email: pubvente@ilo.org

Visit our website: www.ilo.org/publns

CONTENTS

1 Introduction	4
2 What is health microinsurance?	5
3 Does health microinsurance work for low-income clients?	7
4 What are the challenges for health microinsurance and how can they be overcome?	8
5 Ten recommendations to make health microinsurance work	10
Recommendation 1 (Product) – Design simple products	10
Recommendation 2 (Product) – Offer value-added services	12
Recommendation 3 (Product) – Bundle HMI with savings	13
Recommendation 4 (Processes) – Create a positive experience for clients	15
Recommendation 5 (Processes) – Use technology	17
Recommendation 6 (Processes) – Monitor scheme performance	19
Recommendation 7 (Partnerships) – Engage in public–private partnerships	21
Recommendation 8 (Partnerships) – Design smart subsidies	23
Recommendation 9 (Partnerships) – Drive scale through distribution	25
Recommendation 10 (Partnerships) – Partner with health-care providers	27
6 Conclusion	29
7 References	31
8 Appendix: ILO Microinsurance Innovation Facility partners cited	33

1 INTRODUCTION

The high cost of health care can have devastating consequences for low-income households, including having to delay or forego care or being forced to finance health emergencies with loans, savings or sales of assets. Across the globe, the need to pay for health services impoverishes 100 million people each year, over 90 per cent of whom live in low-income countries (Xu et al., 2007). In India, for example, health-related crises affected 42 per cent of the households surveyed by Collins et al. (2009), making health problems the largest drain on their financial resources. The average rural Indian household uses more than one-tenth of its total out-of-pocket expenditure, and even over one-fifth of its non-food expenditure, for health care; every tenth rural household in India has become either poor or poorer through out-of-pocket health-care payments (Ladusingh and Pandey, 2013). In fact, around 5 per cent of Indian households above the poverty line fall into poverty because of health-care payments, translating into approximately 34.6 million individuals (Shahrawat and Rao, 2012).

Access to essential health care is a human right and a social and economic necessity (ILO, 2012; United Nations, 1948). The International Labour Organization (ILO) is calling for countries to define minimum social security benefits – including those for health – as soon as conditions allow (ILO, 2012). Many countries are pursuing government-sponsored health insurance as a primary means to extend and supplement social protection, yet the majority of low-income households in developing countries lack adequate access to public or private health insurance programmes.

Other pressures are mounting. Many countries are scaling down welfare programmes to cope with the consequences of aging populations (The Economist, 2012). In Africa, multiple epidemiological crises drive up health-care costs, while chronic diseases are on the rise and are expected to overtake communicable diseases as the continent's greatest health challenge by 2030 (The Economist Intelligence Unit, 2012). Governments must cope with these and other adverse trends, while facing fiscal constraints. Hence, they need to carefully consider the available health-financing options, one of which is health microinsurance (HMI).

This paper is based on lessons learned by partners of the ILO's Impact Insurance Facility during the six years beginning in 2008 (see appendix). After broadly defining HMI and discussing recent evidence of its impact on clients, the paper outlines key challenges and presents ten recommendations for practitioners, governments and other stakeholders to improve product design, streamline processes and foster necessary partnerships: in short, to make HMI work.

2 WHAT IS HEALTH MICROINSURANCE?

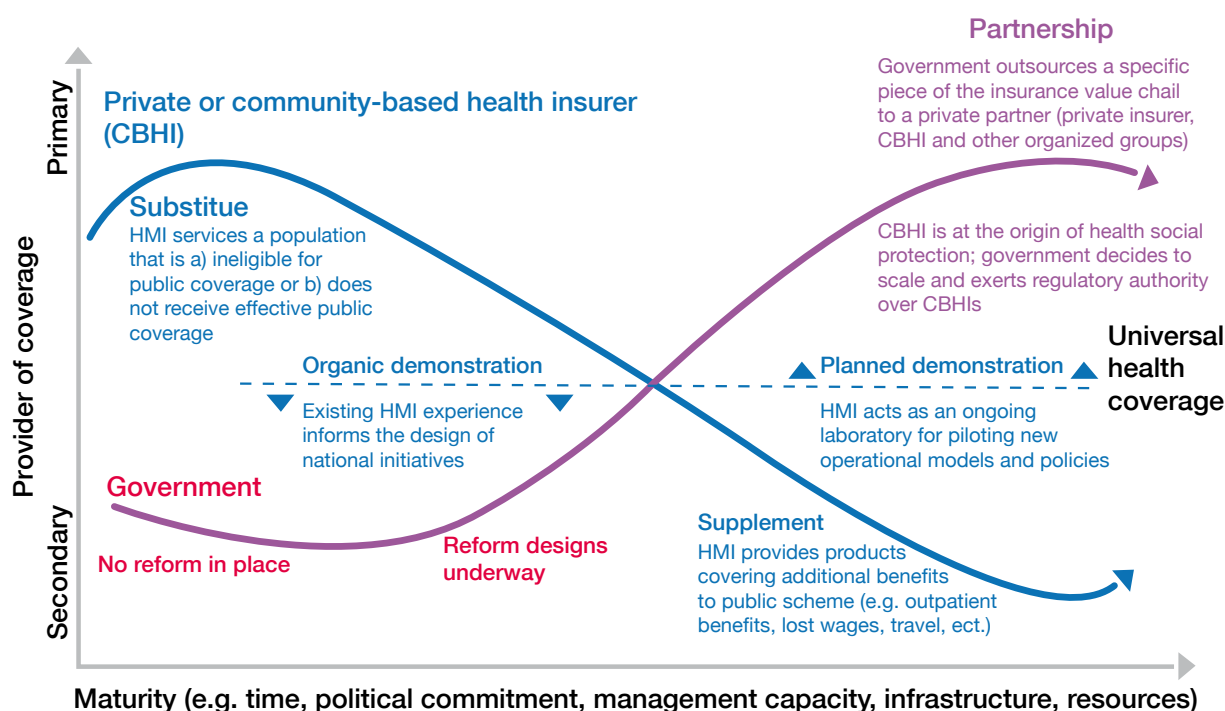
There is no single pathway to universal health coverage (UHC), and most government solutions are based on several health-financing options (Scheil-Adlung, 2013). Health insurance is one option that can complement the overall assets of the public sector and contribute to improving access to health services. All financing solutions, public and private, must also consider how to deliver value for money, something that requires efficient and effective health-care delivery models.

HMI concerns the provision of insurance services to low-income households in exchange for regular premiums that are in proportion to the risks involved (Churchill, 2006); it is the most popular type of microinsurance in the world (Roth et al., 2007). HMI can help low-income households cope with health shocks, strengthen the sustainability of health-care providers and help governments to achieve UHC.

HMI schemes are diverse and can differ in several respects.

- Interaction with public sector initiatives:** HMI can both complement and supplement the public sector's efforts to achieve UHC (Kimball et al., 2013). HMI schemes, and in particular community-based ones, may be better equipped to identify low-income households, to enrol them and to collect premiums from them – a task with which governments have traditionally struggled. This capacity can enable HMI schemes to lay a foundation which can then be scaled up by the public sector, or to perform insurance functions on behalf of governments via public–private partnerships. As UHC initiatives progress, the role of HMI schemes is to supplement the services that are covered by the public sector, and to innovate and demonstrate how to improve performance. The evolving role of HMI as UHC expands is illustrated in Figure 1.

Figure 1. The role of HMI in the expansion of UHC



Source: Kimball et al., 2013

- **Products:** Some HMI products focus on benefits that offset expenses associated with a hospital stay, such as transportation, accommodation or lost wages. Commonly referred to as “hospital cash”, these products usually pay benefits based on a fixed amount per day of hospitalization and are thus fairly simple to sell and service. For this reason, hospital cash products, and some others, such as those that pay a fixed benefit per claim event regardless of the loss incurred, can provide a first point of entry for providers serving the low-income market. Other HMI products provide benefits to offset the cost of health-care services – either inpatient, outpatient or both. Here too, the products can be simple, such as with critical illness cover, which pays fixed benefits for a defined set of illnesses. Once the diagnosis of the covered illness is verified, the claim can be settled. Other HMI products are more complex, for example, those that cover some or all of the costs of a comprehensive set of inpatient and outpatient health risks.
- **Focus and scope of benefits:** The actual needs of low-income households and their ability and willingness to pay premiums vary among target markets. Insurers need to communicate with and in particular listen to clients to find out what they need most, in order to prioritize which benefits to focus limited resources on.
- **Cashless or reimbursement:** Clients receive benefits under HMI either through reimbursement after submitting a claim for a covered health event, or via a “cashless” mechanism, whereby the insurer or its administrator pays the health-care provider on behalf of the client.
- **Payment to health-care provider:** Health-care providers are compensated for the services they provide to patients through different payment methods, such as fee-for-service, per-day, per-admission and capitation. Under a capitation system, health-care providers are paid a pre-determined amount for a fixed period for each enrolled person assigned to them, regardless of whether that person seeks care. Each approach has pros and cons; the goal remains to establish fair, rational payments and appropriate use of good-quality services (Le Roy and Holtz, 2011).
- **Delivery model:** HMI can be delivered through a variety of models, including mutual health organizations, partner-agent schemes and social health insurance programmes. A mutual health organization is based on a group with common characteristics, owned by its policyholders and characterized by participatory decision-making. Partner-agent schemes are based on a partnership between a risk carrier (for example, a commercial insurer or an NGO) and a distribution channel (for example, a microfinance institution). Under a social health insurance programme, governments launch and fund an HMI scheme and define eligibility requirements in order to provide a defined population with health insurance.
- **In-house administration and outsourcing:** Administrative tasks, such as managing claims processes, can either be managed in-house or outsourced to a third-party administrator (TPA) (Le Roy and Holtz, 2011). The choice depends on the context. One advantage of TPAs is that they enable insurers to interact with a single entity (the TPA) rather than a multitude of beneficiaries. TPAs can also have substantial administrative expertise and technology platforms, which HMI schemes often lack. A downside of TPAs is that the insurer has fewer opportunities to interact with clients and health-care providers, leading to less control and a weaker understanding of how the scheme is performing. It is important that incentives and performance targets are aligned between insurers and TPAs, based on indicators such as volume, timeliness, accuracy, client satisfaction, claim costs and administrative expenses.

HMI schemes evolve over time. They often begin with a simple benefit package when they and the target market are less familiar with HMI. Private sector HMI initiatives (for example, a community that sets up a mutual) may begin independently, before government initiatives take root. Benefits and product features in the market can eventually expand, often aided by government or donor subsidy.

3 DOES HEALTH MICROINSURANCE WORK FOR LOW-INCOME CLIENTS?

HMI can deliver client value¹ through better access to health care, lower out-of-pocket expenses, less reliance on “burdensome” financing strategies, improved peace of mind, and the promotion of preventative measures (Dalal et al., 2014):

- **Better access to health care:** HMI can help improve access to health care through a range of interventions, including outpatient benefits, discounted networks of outpatient care providers that meet minimum quality standards, and call centres offering medical advice (Dalal et al., 2014; Zimmerman et al., 2013). For example, in Guatemala, Aseguradora Rural’s HMI product for women encourages clients to use services. Research shows that 20 per cent of the insured women would not have used the covered health-care services without HMI (Zimmerman et al., 2013). Similarly, in India, CARE Foundation piloted an outpatient insurance card that covered cashless visits to community health workers and which resulted in more frequent outpatient visits (Mahal et al., 2013).
- **Lower out-of-pocket expenses:** Cashless HMI can reduce the out-of-pocket expenditure of the insured (Dalal et al., 2014; Zimmerman et al., 2013). In particular reducing out-of-pocket expenditure for outpatient services and medicines has a strong effect on reducing impoverishment (Sharawat and Rao, 2012).
- **Less reliance on “burdensome” financing strategies:** Low-income households with HMI are less reliant on “burdensome” financing strategies, such as selling productive assets (Dalal et al., 2014; Zimmerman et al., 2013). For example, in Kenya, people insured under the Afya Yetu Initiative were far less likely than their uninsured counterparts to draw on their savings to pay the costs of hospitalization (26 per cent versus 41 per cent) (Zimmerman et al., 2013).
- **Peace of mind:** Better access to health care, lower out-of-pocket expenses and less reliance on burdensome financing strategies provide low-income households with greater peace of mind, since they need to worry less about how to cover medical expenses (Dalal et al., 2014).
- **Promotion of preventative measures:** Preventative measures, such as the promotion of hygiene, better nutrition, bed nets, and immunization, have been described as “low-hanging fruit”, because they are inexpensive but can have a direct and immediate impact on the health of low-income households (Banerjee and Duflo, 2012). HMI schemes have a natural interest in preventing common illnesses, which are often responsible for the majority of claims (Holtz et al., forthcoming). Evaluating the impact of preventative health services is difficult, particularly in the short term. The experience (though limited to a period of 2 years) of VimoSEWA in India showed, for example, that health education does not necessarily lead to improved health outcomes. Whether and under what circumstances – such as via value-added services bundled with health insurance – preventative interventions may indeed promote value for clients (including better health), and also be viable, is an area for further research.

Despite its potential, HMI does not automatically translate into better health outcomes. Rather, its impact accumulates sequentially (Quinn et al., 2014): First, relevant HMI must be offered and made accessible to low-income households. Second, the target market must decide to adopt the product. Third, insurance in force influences the supply and quality of services that are offered in the community, and insured individuals may change their treatment-seeking behaviour as a result of having insurance. HMI can then lead to improved well-being and lower vulnerability for insured persons and also have positive effects on their communities, including for individuals without insurance. Only when HMI schemes successfully advance through this sequence can they be expected to deliver their full potential client value.

Delivering client value is in the interest of insurers too. Most voluntary HMI schemes experience low renewal rates, sometimes even less than 10 per cent, which thwart scale and viability. Reasons for low renewal rates (and implied low client value) include insufficient information about the HMI product and the functioning of the scheme, low payouts and poor understanding of the insurance concept (Platteau and Ugarte, 2013).

¹ Client value represents the added value of having HMI in comparison to other available risk coping mechanisms, either when claims are made or as a result of changed behaviour caused by owning a policy and trusting that it will be honoured (Dalal et al., 2014; Magnoni and Zimmerman, 2011).

4 WHAT ARE THE CHALLENGES FOR HEALTH MICROINSURANCE AND HOW CAN THEY BE OVERCOME?

HMI schemes face a myriad of complex challenges which complicate the provision of insurance to low-income households. These include determining demand; collecting adequate premiums; providing affordable, comprehensive benefits; distributing products; delivering health care; settling claims; and controlling the cost of medicines.

- **Demand determinants:** The particular needs of low-income households have to be addressed in order to enable them to enrol in, and remain enrolled in, HMI schemes. A lack of understanding about insurance, a false perception of its value, liquidity constraints, lack of trust and other factors can undermine the demand of low-income households for insurance (Matul et al., 2013).
- **Adequacy of premiums:** Insurers find it difficult to calculate and collect an adequate premium for HMI. It is more difficult to estimate the exposure to health risks than, for example, mortality rates. Inadequate actuarial data, systems, and capacity to evaluate factors such as risk-reduction interventions or distribution method, which influence the premium and the performance of the scheme, force many insurers to price using a trial-and-error approach. For example, Microcare in Uganda did not discover that premiums in force were too low early enough to allow timely intervention, a factor that contributed to the eventual termination of the scheme (Greyling, 2013). Regular monitoring of the performance of HMI schemes provides insurers with more information, enabling the calculation of more accurate premiums.
- **Affordable, comprehensive benefits:** Insurance is better suited to cover low-frequency, high-cost events (inpatient services) than high-frequency, low-cost events (outpatient services). Yet outpatient expenses are a constant “dripping tap”, driving three times as many low-income households into poverty as do inpatient expenses (Berman et al., 2010). Meeting demand for coverage of outpatient events requires insurers to adopt a different mindset and use an operating model suited to managing high-volume, lower-cost transactions. Bundling insurance for low-frequency, high-cost health events (for example, hospitalization) with additional services for outpatient health care provides one way to begin to address this dilemma.
- **Distribution:** Wider distribution drives growth and economies of scale, and can also increase administrative costs (Koven et al., 2013). In general, HMI should be offered on a group basis, to minimize acquisition costs, adverse selection and low demand and follow-through from individuals. Some simple products, however, such as hospital cash or coverage that complements a mandatory product, can be offered on a voluntary basis to individuals. Examples of complementary benefits include access to an expanded network of contracted providers, often comprising higher-cost private facilities, or a higher sum assured which “tops off” the mandatory product benefits. Low-cost distribution channels, such as retailers and utilities, have sold mostly simple products, usually to cover life and accident risks. Yet, their low-touch sales approach makes it difficult to educate clients about product features, such as empanelled hospitals, waiting periods and exclusions. Higher-touch distribution channels, such as sales agents recruited from community-based organizations or microfinance institutions, can provide clients with advice about HMI, but training and incentives increase costs.
- **Health-care delivery:** The delivery of client value ultimately depends on the availability and quality of health-care services. In large areas of developing countries, health-care services are not available or suffer from poor quality. Allied health-care professionals, such as community health workers, and use of technology-enabled health care (for example, telemedicine) can help create models for health-care delivery that promise to reach many more people with services of higher and more consistent quality, at even lower cost. For example, the Union des mutuelles de santé de Guinée forestière and the Centre for International Development and Research have offered HMI in Guinea that deploys trained health workers to carry out antenatal visits in the villages.

- **Claims settlement:** Claims settlement in HMI is more complicated than in other types of microinsurance because a third party – the health-care provider – is involved and because products are complex (Le Roy and Holtz, 2011). Some health-care providers exhibit moral hazard by providing services that may not be medically necessary and even engage in fraudulent behaviour such as billing for services not provided or billing at inflated rates. HMI product features such as the exclusion of pre-existing conditions or waiting periods are designed to manage adverse selection and claim costs. Yet such provisions, in addition to monitoring health-care providers, require health insurers to establish more complex (and costly) administrative processes to verify the appropriateness and legitimacy of claims (Rendek et al., 2014). Health insurers need to verify that clients actually received treatment, that their treatment was appropriate, and that the treatment was a covered service – a much more complex proposition than, for example, verifying a life insurance claim upon receipt of a death certificate. Simple benefit packages and administrative procedures can make processes more streamlined.
- **Medicines:** High margins imposed by pharmaceutical companies, supply chain constraints, a tendency to overprescribe and use branded drugs, and high demand for medicines result in significant pharmaceutical costs (Chandani and Garand, 2013). Indeed, pharmaceuticals often account for the majority of health-care costs. Evidence from India demonstrates that pharmaceuticals constitute 72 per cent of out-of-pocket health payments (Shahrawat and Rao, 2012). Using standard protocols to promote the use of cost-effective (that is, generic) drugs when medically necessary and educating physicians and their patients about the costs and benefits of various interventions can help control the cost of medicines and improve outcomes. For example, the unwarranted use of antibiotics has been documented in developing and developed countries to be wasteful and even potentially harmful to patients by reducing antibiotic efficacy (World Health Organization, 2014).

5 TEN RECOMMENDATIONS ON HOW TO MAKE HEALTH MICROINSURANCE WORK

The ten recommendations in this report (Figure 2), broadly grouped under products, processes and partnerships, take the previously mentioned general microinsurance and HMI-specific challenges into account. They illustrate key ways of promoting client value and viability.

Figure 2. Ten recommendations for practitioners on how to make HMI work

PRODUCT	PROCESSES	PARTNERSHIPS
1. Design simple products 2. Offer value-added services 3. Bundle HMI with savings	4. Create a positive experience for clients 5. Use technology 6. Monitor scheme performance	7. Engage in public-private partnerships 8. Design smart subsidies 9. Drive scale through distribution 10. Partner with health-care providers

RECOMMENDATION 1 (PRODUCT) – DESIGN SIMPLE PRODUCTS

Simple products can contribute to client value as well as financial viability, since they are easier for clients to understand and they enable streamlined processes. Simple products also serve the interest of distribution channels, whose staff may be less familiar with insurance. Fixed or defined benefit schedules (that is, benefits that are paid in specific amounts without regard to the cost of services utilized), limited benefit categories, few (or no) exclusions, cashless schemes and simple language contribute to a simple product design (Figure 3).

When insurers have a limited understanding of the market, they should conduct a feasibility study that includes market research. It may be prudent to consider launching a simple product, such as hospital cash, first. After they become familiar with the market, insurers are then more able to offer more comprehensive or complex products.

Products with more comprehensive coverage can still qualify as simple with the help of fixed benefits. For example, an HMI product which pays US\$5 per outpatient consultation or US\$100 per inpatient stay does not vary in the allowable benefit per event, regardless of the actual expenses incurred.

Figure 3. Tips for simple products

Use fixed benefits	Avoid exclusions
Minimise benefit types and limits	Avoid waiting periods
Go cashless	Use simple language

Simple products improve a scheme's viability by making claims simpler to adjudicate, facilitating automation and reducing claims errors and rejections. In Bangladesh, SAJIDA Foundation offers a composite product that includes fixed cash benefits for listed inpatient treatments only and provides access to discounted outpatient consultations as a value-added service. Local branch managers are authorized to approve simple claims using a standard protocol (see Recommendation 10). More complex claims are approved by in-house medical advisors or regional coordinators.

Furthermore, insurers should periodically evaluate the pros and cons of product features such as waiting periods, deductibles and co-payments, benefit ceilings, exclusions and requirements to authorise care in advance. These product features limit claims exposure and adverse selection for insurers but complicate administration and undermine client value by making it more difficult for clients to understand which health-care expenses are covered and under which circumstances.

Simple language makes products easier to understand for both clients and distribution channels. Uplift in India simplified the description and number of benefit categories for illnesses, which in turn made it easier for clients to understand the product. CARE Foundation in India even refrained from using the term insurance at all. Since most clients did not understand what the term meant, CARE Foundation referred to its self-funded outpatient insurance as the Aroyga Health Card, emphasizing that the card entitled clients access to a defined set and amount of cashless, convenient, quality primary care services.

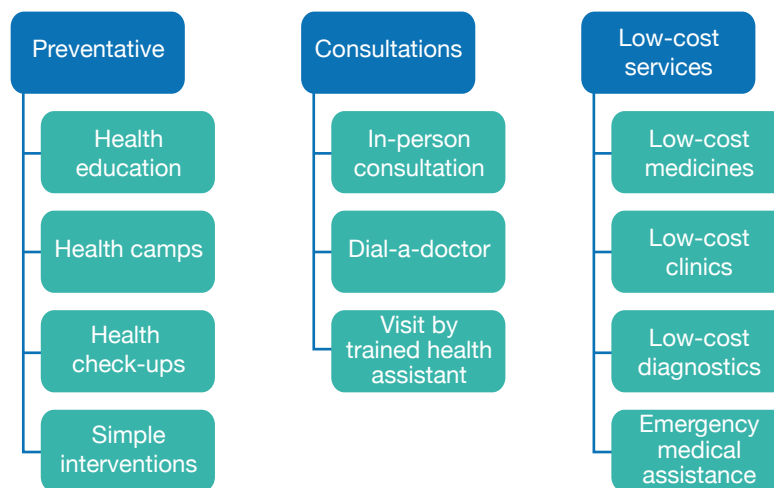
Why?	Further reading
<ul style="list-style-type: none">• Better understanding of the product by clients and distribution channels• Enable streamlined processes for claims, sales and pricing• Minimize claim rejections	<p>M. Matul and A. Dalal: <i>Creating client value: Ten blueprints for microinsurance providers</i>, Client Value Series Brief No. 2 (Geneva, ILO, 2014).</p> <p>M. McCord: <i>Microinsurance product development for microfinance providers</i> (Rome, International Fund for Agricultural Development, 2012).</p> <p>K. Rendek, J. Holtz and C. Fonseca: <i>The moment of truth: Claims management in microinsurance</i>, Microinsurance Paper No. 28 (Geneva, ILO, 2013).</p> <p>Strategies and Tools against Social Exclusion and Poverty (STEP): <i>Health micro-insurance schemes: Feasibility study guide</i> (Geneva, ILO, 2005).</p>

RECOMMENDATION 2 (PRODUCT) – OFFER VALUE-ADDED SERVICES

Striking a balance between client value and financial viability is not easy. Bundling HMI with value-added services helps overcome this challenge. Services such as outpatient consultations provide clients with tangible support to help them cope with frequent risks, and preventative and low-cost services can improve clients' health. HMI providers should consider different types of value-added services, pace their implementation carefully and evaluate their impact to improve their effectiveness.

There are different types of value-added services that HMI schemes may offer (Figure 4). The Indian health mutual Uplift offers a variety of services. It trains field staff of partner microfinance institutions to conduct regular health talks, educating clients about relevant topics. An estimated 15 to 30 per cent of enrolled households attend at least one health talk per year. Uplift also offers a dial-a-doctor service, which provides advice to clients and helps them to access low-cost outpatient services and medicines from a panel of more than 300 outpatient clinics and pharmacies with which Uplift has negotiated discounts. The cost of a dial-a-doctor service for a sample of Indian HMI schemes, including Uplift, is estimated to be 50 Indian rupees (US\$1) per call; around 70 per cent of requests for medical assistance are resolved during the call. Most frequently clients are advised to use over-the-counter medicine, resulting in fewer costs for both the client (travel expenses, absence from work) and the insurer (fewer inpatient visits). Indeed dial-a-doctor services have become the most popular value-added service.

Figure 4. Different value-added services



HMI providers should concentrate on a few value-added services rather than many, to ensure sufficient attention and resources can be devoted to them. Equally, a core HMI product and accompanying value-added service(s) need to be phased in carefully. Preferably, either the HMI product or the value-added service(s) (in either order) should commence and reach some degree of scale and stability before the other is launched. Otherwise, the success of both interventions may falter. Implemented successfully, value-added services not only can enhance client value, they can also encourage renewals and reduce costs, thereby promoting greater financial viability of the HMI scheme.

Why?

- Cost-effective way to complement core HMI product
- Improve tangibility of HMI
- Improve access to outpatient services
- Reduce out-of-pocket expenditure on health-care services
- Encourage clients to take preventative health measures

Further reading

J. Pott and J. Holtz: *Value-added services in health microinsurance*, Microinsurance Paper No. 19 (Geneva, ILO, 2013).

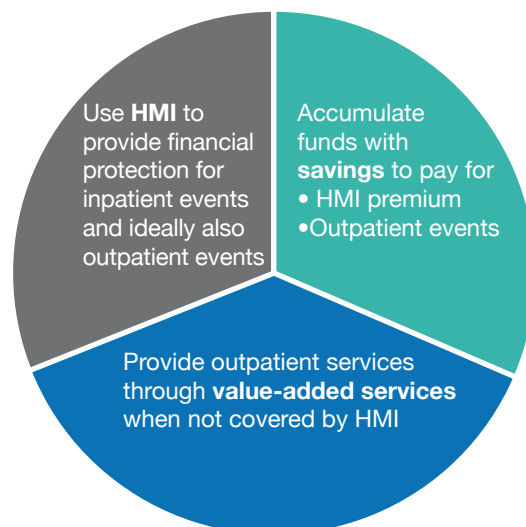
RECOMMENDATION 3 (PRODUCT) – BUNDLE HMI WITH SAVINGS

Striking a balance between client value and financial viability is not easy. Bundling HMI with value-added services helps overcome this challenge. Services such as outpatient consultations provide clients with tangible support to help them cope with frequent risks, and preventative and low-cost services can improve clients' health. HMI providers should consider different types of value-added services, pace their implementation carefully and evaluate their impact to improve their effectiveness.

Low-income households often save money but rarely use their savings for risk management, owing to inflexible saving devices and behavioural constraints (Zollmann, forthcoming). Bundling HMI with savings can not only help low-income households to cope better with health shocks, it can also stimulate demand for HMI (Figure 5). Indeed, HMI and savings are important risk management tools in the “portfolio of the poor” (Collins et al., 2009).

Low-income households need to finance high-frequency, low-cost health care (outpatient services) as well as care that is low-frequency but high-cost (inpatient services). Most unsubsidized HMI schemes refrain from covering outpatient services, owing to the significant challenges to do so viably. Savings can play an important role in encouraging low-income households to put aside money for outpatient expenses that must be paid out of pocket. For example, Changamka introduced a Maternity Savings Card in Kenya, which enables transactions and provides a savings account (Woodman et al., 2013). Users have appreciated that the card is convenient for paying for medical services and prevents them from spending their savings on other things.

Figure 5. Tips for bundling HMI, savings and value-added services



A combination of HMI and savings – alongside wider efforts to improve public health and the quality and efficiency of health-care delivery – can help low-income households cope with inpatient and outpatient health-care expenses. Insurance, with its ability to pool risks, is an ideal tool for less frequent, but significantly more costly, hospitalization; it is less able to cover outpatient services at affordable premiums. Savings can be used to pay for outpatient services. Unfortunately the funds needed to finance frequent outpatient health care often exceed the amount that can be accumulated through household savings. But subsidized premiums (Recommendation 8) and value-added services (Recommendation 2) provide solutions to close this gap.

In China, the New Cooperative Medical Scheme for Rural Residents provides low-income households with solutions to manage health shocks, two of which combine medical savings and health insurance. The combination has proven popular and has helped low-income households cope with medical expenses (Ma et al., 2012).

Savings can also be used to overcome liquidity constraints. Money can be saved throughout the year when it is available, and then used to pay an insurance premium when it is due. In Kenya, Safaricom, Britam and Changamka have eased clients' liquidity constraints by offering a savings-linked composite product, which also covers inpatient and outpatient treatment, using mobile technology (Recommendation 5) to facilitate premium collection.

Why?	Further reading
<ul style="list-style-type: none">• Complement existing risk management tools• Finance inpatient and outpatient services• Ease liquidity constraints to pay premiums	<p>R. Rusconi: <i>Savings in microinsurance: Lessons from India</i>. Microinsurance Paper No. 14 (Geneva, ILO, 2012).</p> <p>B. Woodman, T. van Bastelaer, D. Long and M. Chatterji: <i>Saving money, saving lives: An inquiry into a micro-savings maternity product in Kenya</i> (Bethesda, MD, Abt Associates, 2013).</p>

RECOMMENDATION 4 (PROCESSES) – CREATE A POSITIVE EXPERIENCE FOR CLIENTS

All elements of the microinsurance value chain (for example, premium collection and claims), need to accommodate the needs of low-income households in order to provide them with a good experience of insurance (Figure 6). If clients have a good experience and perceive the value of HMI, the word-of-mouth effect can contribute to increased enrolment and renewals. Communicating requirements clearly, easing liquidity constraints, assisting clients during the claims process and shortening turnaround times can all improve the experience a client has with insurance.

Clients need assistance to identify health-care providers who are available and deliver appropriate, quality care; this is especially important when benefits vary depending on where health care is obtained. Placing a representative of the insurer at hospitals to assist clients and providing 24/7 hotlines, which are ideally free of charge to clients, are further ways to improve the experience clients have when accessing care and making claims.

Figure 6. Components of a positive client experience



Insurers should also communicate their requirements for premium payment and renewals, so that clients do not unintentionally lose their HMI. In India, Swayam Shikshan Prayog’s community-led HMI experienced low renewal rates, partly because clients did not know how and where to pay their premiums (Platteau and Ugarte, 2013).

Liquidity constraints make it difficult for low-income households to afford insurance. Flexible payment methods can help overcome this problem. Premium collection can, for example, coincide with the harvesting season, when low-income households have more income. Shortening policy periods also addresses liquidity constraints. In India, CARE Foundation replaced a 12-month policy with a 6-month policy and subsequently experienced increased take-up. Cashless schemes provide a further way of easing liquidity constraints and enable streamlined processes. Such schemes also make it possible for a client to avoid out-of-pocket expenses when accessing care, except for any specific, generally smaller payments such as co-payments, or to pay for services not covered by the scheme. In Nigeria, Hygeia Community Health Plan offers inpatient and outpatient benefits to clients on a cashless basis.

Claims are the moment of truth in insurance. Clients receive value from insurance when a claim is settled, and this exerts a positive influence on enrolment and renewals. Claims processes need to be simple and efficient, so that claims are paid quickly and the timing of payments is communicated clearly. For example, SAJIDA Foundation, a microfinance initiative in Bangladesh, simplified its claims documentation requirements and claims adjudication process. As a result, turnaround time was reduced by more than 50 per cent, significantly improving client value.

Why?

- Clients perceive value in HMI
- Encourage enrolment and renewals
- Good experience leads to trust and emergence of culture of insurance

Further reading

M. Matul and A. Dalal: *Creating client value: Ten blueprints for microinsurance providers*, Client Value Series Brief No. 2 (Geneva, ILO, 2014).

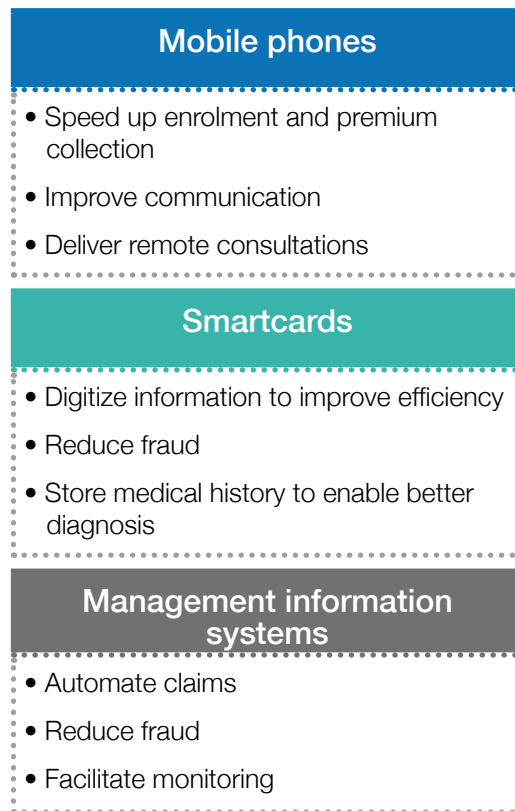
M. Matul, A. Dalal, O. De Bock and W. Gelade: *Why people do not buy microinsurance and what can we do about it*, Microinsurance Paper No. 20 (Geneva, ILO, 2013).

K. Rendek, J. Holtz, and C. Fonseca: *The moment of truth: Claims management in microinsurance*, Microinsurance Paper No. 28 (Geneva, ILO, 2013).

RECOMMENDATION 5 (PROCESSES) – USE TECHNOLOGY

Technology can increase efficiency and client value across the entire microinsurance value chain. Mobile phones speed up enrolment, premium collection and other processes, strengthen communication with clients, and help deliver remote consultations; smartcards reduce fraud and enable access to medical records during treatment; management information systems also reduce fraud, facilitate monitoring and enable automation (Figure 7).

Figure 7. The impact of technology on client value and business viability



Mobile phones can facilitate enrolment, speed up premium collection and improve communication with clients. In India, the mobile application used by the Palmyrah Workers Development Society for its HMI scheme has shortened the enrolment process from 15 to 4 days and also supports the reconciliation and auditing of premium payments.

Smartcards facilitate the storage and transmission of data such as client demographics and claims history, and can use biometric data (for example, fingerprints) to reduce identity fraud. Smartcards can deliver advantages across the range of insurance functions, as demonstrated by the Government of India's Rashtriya Swasthya Bima Yojana (RSBY) scheme and Hygeia Community Health Plan in Nigeria. Both schemes have been able to improve accuracy in verifying client identity and eligibility, thereby reducing fraud and increasing administrative efficiency.

HMI schemes can use basic technology, including spreadsheet software such as Excel, or cloud-based tools, which are increasingly available, to streamline processes and manage moral hazard, fraud, claim costs and administrative costs. In India, Uplift has used Excel to develop a standardized and automated claims decision-making tool and is currently creating a web-based application to enhance access to the tool across more locations. HMI schemes can either develop in-house management information systems or outsource information management to a TPA.

Mobile technology can also be used to provide dial-a-doctor services (Recommendation 2). Similarly, health workers can be equipped with portable devices to bring health care supported by remote medical staff to people, instead of requiring people to come to health-care facilities. In India, CARE Foundation piloted an outpatient insurance product which relied on community health workers trained to provide basic health services with the help of technology-enabled diagnostic protocols and the support of remote doctors. The technology empowers lower-cost, qualified people to provide basic services, while referring more complex cases to physicians.

Technology solutions remain fragile in many settings and the benefits of technology do not automatically materialize. Solutions need to reflect operating conditions on the ground. Constraints such as sporadic electricity or internet connectivity, the existing infrastructure (including that of health-care providers), process design and ability and acceptance of users can limit the functionality of technology.

Why?	Further reading
<ul style="list-style-type: none">• Improve access to outpatient services• Shorten claim turnaround times• Enable streamlined processes• Reduce fraud	<p>E. Cimon, B. Harnasch, P. Gross and C. Fonseca: <i>Removing obstacles to access microinsurance</i>, Microinsurance Paper No. 27 (Geneva, ILO, 2013).</p> <p>P. Le Roy and J. Holtz: <i>Third party payment mechanisms in health microinsurance</i>, Microinsurance Paper No. 13 (Geneva, ILO, 2011).</p> <p>J. Pott and J. Holtz: <i>Value-added services in health microinsurance</i>, Microinsurance Paper No. 19 (Geneva, ILO, 2013).</p> <p>P. Prashad, D. Saunders and A. Dalal: <i>Mobile phones and microinsurance</i>, Microinsurance Paper No. 26 (Geneva, ILO, 2013).</p>

RECOMMENDATION 6 (PROCESSES) – MONITOR SCHEME PERFORMANCE

Improving the performance of HMI schemes is iterative, and small tweaks can make a big difference. When HMI schemes monitor their operations, they can identify deficiencies and areas for improvement (Figure 8). Quantitative and qualitative information about the performance of HMI schemes can be gathered, analysed and used to improve both client value and scheme viability. For example, MicroFund for Women, a microfinance initiative in Jordan, experienced a stable and below-target claim ratio for its Caregiver hospital cash product, which triggered a decision to improve client value by enhancing benefits as well as reducing the premium.

Figure 8. Tips for effective monitoring



PACE, the Impact Insurance Facility’s client value assessment tool, helps organizations examine insurance products from the client’s perspective by comparing them with other formal and informal risk management tools. PACE provides a framework within which to assess client value and the processes related to it across four dimensions: product, access, cost and experience. It allows practitioners to identify, consolidate, and then prioritize potential improvements. For example, SAJIDA Foundation’s previously mentioned initiative to reduce claims payment turnaround times that led to a reduction in turnaround time of more than 50 per cent was based on findings from analysis using PACE.

Quantitative information about the performance of HMI schemes should be gathered to complement a PACE or other analysis, and should include data on distribution channels and health-care providers. Insurers need to define targets for performance indicators such as incurred claims ratio, renewal ratio and solvency ratio, and to monitor them in order to improve client value and viability. Claims data should also be segmented and analysed in specific ways (that is, by diagnosis, health-care provider, and so on) to obtain more precise information to calculate premiums, monitor performance, and identify areas to enhance client value, better manage costs, and identify and address fraud. There is, moreover, a need for unitized, comparable statistics and longitudinal studies to better understand the impact of HMI on health outcomes (Dalal et al, 2014).

Insurers should also gather and analyse qualitative information. Clients can be asked to submit feedback after enrolment, renewal and claims settlement. In India, CARE Foundation's HMI scheme included a specific step to ask beneficiaries about their satisfaction with services. Client complaints provide a valuable source of feedback, highlighting operational deficiencies or misunderstandings by the client, to which insurers can respond. In Nigeria, Hygeia Community Health Plan has introduced a formal policy which clarifies how complaints are handled. Distribution channels, employees and health-care providers provide further sources for feedback.

Why?

Identify potential for:

- better client value
- cost savings
- process improvements
- more constructive partnerships

Further reading

M. Matul and E. Kelly: *How to conduct a PACE client value assessment: A technical guide for microinsurance practitioners* (Geneva, ILO, 2012).

T. Sandmark, A. Simanowitz, V. Faber, M.G. Genazzini and B. Opdebeeck: *Social performance indicators for microinsurance: A handbook for microinsurance practitioners*,

http://www.microinsurancenetwork.org/publication/fichier/Social_performance_indicators_for_microinsurance_workshop_report.pdf [accessed 3 December 2013].

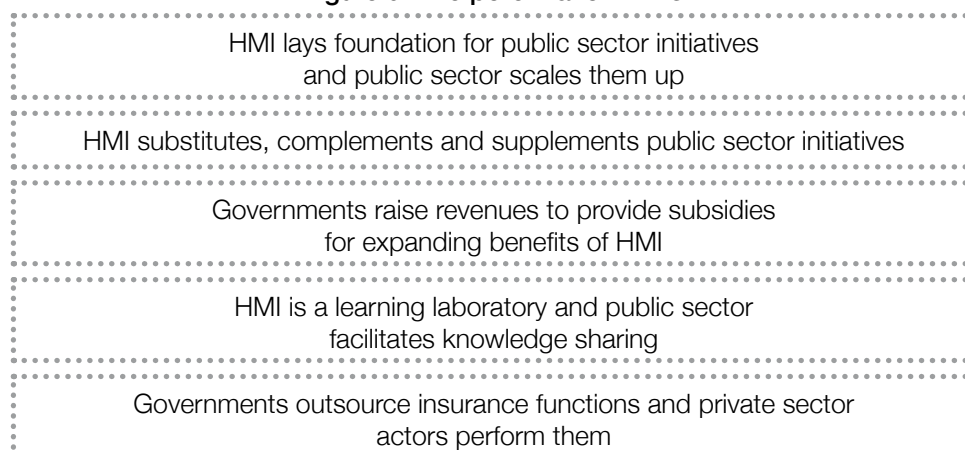
J. Wipf and D. Garand: *Performance indicators for microinsurance: A handbook for microinsurance practitioners, 2nd edition* (Luxembourg, ADA, 2010).



RECOMMENDATION 7 (PARTNERSHIPS) – ENGAGE IN PUBLIC–PRIVATE PARTNERSHIPS

Public and private insurance initiatives co-exist and should be designed to reinforce each other. As UHC initiatives evolve, HMI can support public sector efforts to achieve UHC in different ways. Equally, governments can raise revenue to provide subsidies for HMI, support the operation of HMI schemes and share best practice to improve and expand HMI (Figure 9). This calls for constructive partnerships and requires both sides to define and communicate clear roles and objectives.

Figure 9: The potential of PPPs



HMI can lay the foundation for public sector initiatives. In Thailand, the Government used early community-based health-financing schemes to establish a health insurance programme for informal workers. Later, it merged schemes into a single programme covering the entire population. As UHC initiatives progress, HMI schemes can still complement and supplement services provided by the public sector. HMI products may cover services not covered by the government, such as outpatient services, spectacles or dentistry, or expand access to private health-care providers. They may also provide additional or “top-up” benefits to complement existing benefits. For example, in Kenya, the Afya Yetu Initiative (an NGO) offers three health insurance products that provide additional coverage on top of the Government’s National Health Insurance Fund (NHIF). To illustrate, one product covers an additional US\$115 above the maximum NHIF benefit amount for an annual premium of US\$4.35 (Koven et al., 2014).

Outsourcing insurance functions to private sector partners including insurance companies, community-based organizations, technology providers, and others allows governments to benefit from the private sector’s strengths. For example, private sector partners, in particular community-based ones, may be better equipped to identify, enrol and collect premiums from low-income households – a task with which governments have traditionally struggled. Similarly, the technical competency of insurers in areas such as pricing and product development can be exploited. The governments in Kenya and the Philippines work with the private sector to carry out front-end insurance functions, such as enrolment. In India, the Government also outsources back-end insurance functions, such as claims administration, as well as assumption of financial risk, to insurers.

Governments can also facilitate knowledge transfer between HMI and public sector initiatives. HMI can serve as a laboratory, where innovations can be more nimbly tested and examples of best practice can emerge. In Tanzania, HMI schemes – the Self-Managed Health Insurance Schemes (SMHIS) – were initially perceived by the Government as competitors of the public sector’s Community Health Funds (CHFs). Subsequently, the Government realized that it could benefit from the innovation of the SMHIS. This precipitated a hybrid approach – the Self-Managed Community Funds – that was launched in 2011.

The private sector can benefit in other ways from government collaboration. In Cambodia, Groupe de recherche et d'échanges technologiques (GRET) Sokapheap Krousat Yeugn (SKY) introduced capitation as a health-care provider payment method. The support of the Ministry of Health was vital to alleviate concerns of public health clinics that were new to capitation, and to promote a successful outcome of the negotiations.

Why?

Public sector can

- subsidise expansion of coverage
- share lessons learned
- set standards and monitor scheme performance
- mediate between private sector actors

Private sector can

- foster innovation
- perform insurance functions on behalf of government
- lay foundation for public sector initiatives
- complement and supplement services of public sector

Further reading

M. Kimball, C. Phily, A. Folsom, G. Lagomarsino and J. Holtz: *Leveraging health microinsurance to promote universal health coverage*, Microinsurance Paper No. 23 (Geneva, ILO, 2013).

J.M. Solana and C. Fonseca: *Making microinsurance PPPs work*, Microinsurance Paper No. 36 (Geneva: ILO, forthcoming).

To minimize potential pitfalls, subsidies need to be smart (Figure 10), meaning that they have a clear objective, are well targeted and address the priorities possible within available resources. Additionally subsidies should be subjected to good monitoring and evaluation, have a clear exit or long-term financing strategy, and promote efficient use of health-care services. Unless the nature of a temporary subsidy is communicated and understood, people can be caught by surprise when the subsidy ends or is reduced. Subsidies can also have less impact on schemes that are not well managed or if the products are not relevant. Moreover, equity subsidies tend to benefit wealthier households disproportionately unless they specifically target the poor through means testing or other approaches. Equity subsidies also tend to be permanent even if they are intended to be temporary, requiring long-term financing commitments. Finally, non-permanent subsidies require an exit strategy, which might include the complete removal of the subsidy, reduction in the amount of subsidy, reduction in the number of targeted beneficiaries or replacement of the funding source.

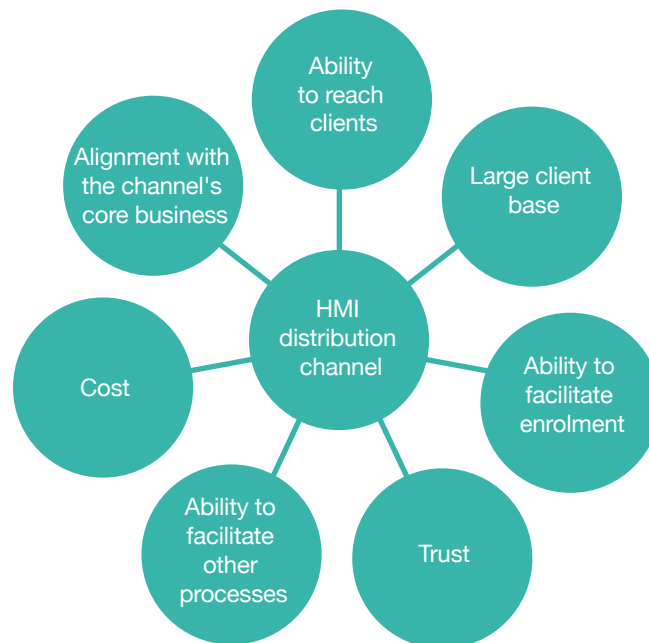
Why?	Further reading
<ul style="list-style-type: none"> • Make premiums affordable for clients • Support insurance market development and UHC • Invest in technology infrastructure for insurance • Raise awareness of insurance 	<p>I.A. Odeyemi and J. Nixon “The role and uptake of private health insurance in different health care systems: Are there lessons for developing countries?”, in <i>ClinicoEconomics and Outcomes</i> (2013, Vol. 13, No. 5), pp. 109–118.</p> <p>S. Shoree, R. Ruchismita and K.R. Desai: <i>Evaluation of RSBY’s key performance indicators: A biennial study</i> (Chennai: Centre for Insurance and Risk Management, 2014).</p> <p>R. Vargas Hill, G. Gajate-Garrido, C. Phily and A. Dalal: <i>Using subsidies for inclusive insurance: Lessons from agriculture and health</i>, Microinsurance Paper No. 29 (Geneva, ILO, 2014).</p>

RECOMMENDATION 9 (PARTNERSHIPS) – DRIVE SCALE THROUGH DISTRIBUTION

Distribution channels play a crucial role in achieving scale and can also improve non-sales processes, such as claims settlement. Several criteria should be taken into account when selecting a distributor (Figure 11).

Selling and servicing health insurance requires a high-touch, advice-based approach and a focus on enrolling groups through intermediaries such as microfinance institutions, cooperatives or networks of agents. Distribution partners must be adequately trained to provide proper advice about HMI.

Figure 11. Selection criteria for distribution channel



Until clients are familiar with and value HMI, distribution channels such as microfinance institutions that have a large client base can facilitate compulsory enrolment and help achieve scale. Compulsory enrolment circumvents the problem of poor financial literacy and also reduces administrative costs, while selling voluntary HMI through sales agents has proven expensive (Koven et al., 2013).

After the market becomes more familiar with insurance, voluntary products which complement mandatory or government options can be sold to established groups and eventually to individuals. Distribution channels which often have a larger, established presence in low-income communities and that are perceived as trustworthy by the target market are assets which insurers can leverage (Matul et al., 2013).

Distribution channels can also facilitate non-sales processes. For example, Uplift is a community-based health mutual organization in India that involves its community in claims assessment in order to promote transparency and solidarity, manage potential fraud and strengthen financial sustainability. A community committee is empowered to approve or reject claims in full or in part. Moreover, CARE Foundation in India has used women in rural communities to provide health-care services and sell and service outpatient insurance.

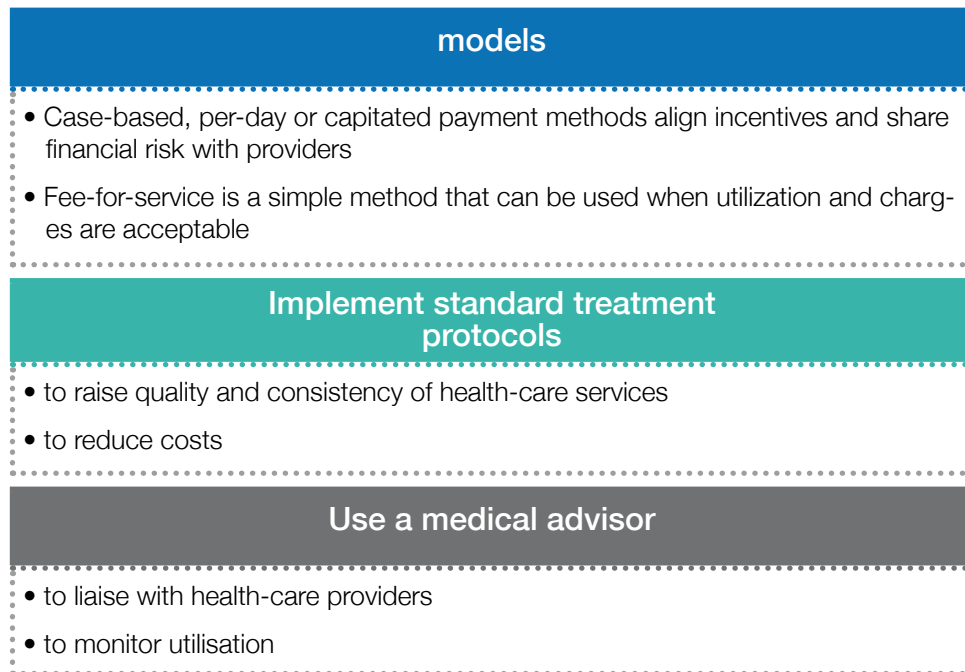
Ideally insurance should align with the core business of its distribution channels. For example, when a financial institution distributes HMI, its borrower clients can be covered for outstanding loan amounts when they fall ill, a benefit to the client that also protects the lender. HMI can additionally offer financial institutions and other distributors an advantage over their competitors when their competitors do not offer HMI. All previous recommendations in this paper need to be embraced, though, as poorly designed products can have a negative effect on customer loyalty (Banerjee et al., 2014).

Why?	Further reading
<ul style="list-style-type: none">• Achieve scale and reach new markets• Control costs• Leverage distributors for more than just sales (trust, claims facilitation, provision of value-added services)• Enhance client value (convenient point of access for sales and service)	<p>A. Mery, P. Prashad and T. Hoffarth: <i>Microinsurance distribution channels: Insights for insurers</i>, Microinsurance Paper No. 33 (Geneva, ILO, 2014).</p> <p>M. Thom, J. Gray, Z. Müller and J. Leach: <i>Scale: Thinking big</i>, Microinsurance Paper No. 30 (Geneva, ILO, 2014).</p>

RECOMMENDATION 10 (PARTNERSHIPS) – PARTNER WITH HEALTH-CARE PROVIDERS

Managing health-care providers, including hospitals and pharmacies, is crucial to ensure the provision of high-quality health-care services and to control costs. Appropriate compensation models, standard procedures, claims coding and medical advisors can enable effective and efficient management of health-care providers (Figure 12). Together with monitoring (Recommendation 6), these instruments encourage appropriate use of health care in exchange for fair payments when a third party – the health-care provider, concerned with delivering health care and generating revenue – is involved.

Figure 12. Tips for managing health-care providers



Some payment methods, such as case-based, per-day and capitation payment, have greater potential to align incentives and control costs than fee-for-service payments. Yet, they present incentives to limit care, and require different monitoring. For example, per-case payments for inpatient care transfer the financial risk for the length of stay to the health-care provider. Because the case rate is the same regardless of length of stay, a health-care provider will have a financial incentive to discharge the patient sooner rather than later.

Alternative payment methods are usually more difficult to negotiate with health-care providers. In Cambodia, GRET SKY transitioned to a capitation mechanism to limit the administrative costs associated with fee-for-service claims, limit its exposure to claim costs and align incentives to manage utilization. The factors contributing to its success included gaining the support of the Ministry of Health, engaging in transparent negotiations on rates, and importantly, creating a demonstration effect with a small number of health facilities before extending the effort to other providers.

Standard treatment protocols and other methods to optimize medical practice support health-care provider management, as does claims coding (Rendek et al., 2014). These can raise standards and consistency of health-care services and reduce costs, yet HMI schemes must balance the potential benefits with the cost of developing, implementing and monitoring them. In Nigeria, a treatment protocol for hypertension, a frequently occurring condition among clients, allowed Hygeia Community Health Plan to reduce costs for hypertension cases. The protocol was also beneficial for clients because it contributed to shifting care from more informal providers such as healers or medicine vendors to modern health-care providers such as medical doctors. Although an impact of the insurance programme on blood pressure in the entire target population could not be found, a preliminary sub-group analysis suggests a decrease in blood pressure in the treatment communities (Gustafsson-Wright, 2013).

Using medical advisors allows HMI schemes to assess claims, negotiate rates and oversee delivery of care with health-care providers. But their role should focus on activities that require clinical expertise, since clinicians can drive up administrative costs. In Bangladesh, SAJIDA Foundation asks field staff to review simple claims using a standard protocol. Only more complex claims are submitted to the in-house medical doctor for review.

Why?	Further reading
<ul style="list-style-type: none">• Align incentives of HMI schemes and health-care providers• Improve quality of health-care services• Control costs• Reduce fraud	<p>P. Le Roy and J. Holtz: <i>Third party payment mechanisms in health microinsurance</i>, Microinsurance Paper No. 13 (Geneva, ILO, 2011).</p> <p>B. Loevinsohn: <i>Performance-based contracting for health services in developing countries</i> (Washington, DC, World Bank, 2008).</p>

6 CONCLUSION

HMI is not only about insurers and clients. Its success in each market context depends on collaboration which reflects and balances the capabilities and objectives of a range of actors consisting of governments, insurers, health-care providers, distribution channels, administrators, suppliers and donors. Good communication among stakeholders can identify the needs of each party and set forth roles and responsibilities which serve common objectives (Figure 13).

Figure 13. Guiding principles for HMI stakeholders

Insurers	Health-care providers	Governments	Donors	Distribution channels
<ul style="list-style-type: none"> • Develop and implement simple, client-centred products and processes • Train other stakeholders on how to use insurance and in health promotion • Coordinate the development and implementation of new products and processes with other stakeholders 	<ul style="list-style-type: none"> • Provide good-quality, equitable services for a fair price • Embrace standards which optimize the quality and efficiency of medical services • Engage in constructive partnerships with HMI programmes 	<ul style="list-style-type: none"> • Create an enabling environment for inclusive insurance • Leverage HMI to complement and support public sector initiatives • Provide smart subsidies for equity, better health and to address market inefficiencies • Promote public health services 	<ul style="list-style-type: none"> • Provide smart subsidies for equity and better health and to address market inefficiencies • Adopt a mid-to long-term approach for engagement • Measure impact 	<ul style="list-style-type: none"> • Engage in ethical sales • Educate and advise clients about insurance • Promote better health

HMI can deliver client value and support efforts to achieve UHC. This synthesis paper presents ten recommendations to guide practitioners, policymakers and other stakeholders on how to deliver client value while promoting viability in a dynamic and challenging environment. Numerous examples confirm the failure of voluntary HMI schemes to achieve viability in the absence of on-going subsidy. Challenges abound to deliver quality health care efficiently in the face of health-care inflation, growing incidence of chronic disease, aging populations, high administrative costs, fiscal constraints, poor infrastructure, and more. Better design of products and processes is essential, as are constructive partnerships, if HMI is to deliver its potential (Figure 14).

Figure 14. Impact of HMI products, processes and partnerships on client value and financial viability

Client value	Financial viability
Simple products	<ul style="list-style-type: none"> • Easier to understand • Build culture of insurance • More efficient and accurate claims adjudication • Easier to sell
Value-added services	<ul style="list-style-type: none"> • Complement core insurance product • Improve access to care (e.g. prevention, consultations) • Lower out-of-pocket expenditure • Provide tangible benefits • Improve health • Reduce claims • Enhance sales and persistency
Savings	<ul style="list-style-type: none"> • Ease liquidity constraints - Accumulate funds to finance out-of-pocket expenditure for health care - Finance insurance premiums • Potential for cross-selling • Enhance persistency
User-friendly processes	<ul style="list-style-type: none"> • Quicker claims turnaround times • Simple claims submission requirements • Flexible payment methods • Lower acquisition and claims costs • Promote enrolment and renewals
Technology	<ul style="list-style-type: none"> • Facilitate premium collection • Enable health-care service delivery • Support cashless mechanisms • More cost-effective processes • Reduce fraud
Monitoring	<ul style="list-style-type: none"> • Better service quality • Feedback and complaint mechanism • Reduce fraud • Improve pricing and benefit packages • Identify product and process improvements
Public-private partnerships	<ul style="list-style-type: none"> • Expanded coverage • Lower out-of-pocket expenditure (through subsidy) • Access to subsidies • Opportunities to perform insurance functions on behalf of governments • Governments can facilitate pooling of risks and sharing of knowledge
Smart subsidies	<ul style="list-style-type: none"> • Affordable premiums • More comprehensive benefits • Investment in infrastructure • Exit strategy
Distribution channels	<ul style="list-style-type: none"> • High-touch support for advice and services, such as outpatient consultations • Convenient, trusted points of access • Outreach (scale) • Access new markets • Efficient support of processes, such as claims settlement
Health-care provider management	<ul style="list-style-type: none"> • Access to quality health-care services • Reduce out-of-pocket expenditure • Reduce fraud • Lower claims costs • Align incentives of HMI scheme and health-care providers

7 REFERENCES

- Banerjee, A.V.; Duflo, E. 2011. *Poor economics: A radical rethinking of the way to fight global poverty* (New York, Public Affairs).
- Banerjee, A.; Duflo, E.; Hornbeck, R. 2014. *Bundling health insurance and microfinance in India*, Research Paper No. 37 (Geneva, ILO).
- Berman, P.; Ahuja, R.; Bhandari, L. 2010. "The impoverishing effect of healthcare payments in India: New methodology and findings", in *Economic and Political Weekly*, Vol. 45, No. 16, pp. 65–71.
- Chandani, T.; Garand, D. 2013. *Lessons learned and good practices in health microinsurance – A guide for practitioners* (Luxembourg, Microinsurance Network).
- Churchill, C. 2006. "What is insurance for the poor?", in C. Churchill (ed.): *Protecting the poor: A microinsurance compendium* (Munich, Munich Re Foundation and ILO), pp. 12–24.
- Collins, D.; Morduch, J.; Rutherford, S.; Ruthven, O. 2009. *Portfolios of the poor: How the world's poor live on \$2 a day* (Princeton, NJ, Princeton University Press).
- Dalal, A.; Zimmerman, E.; Magnoni, B.; Matul, M. 2014. *Is there value in microinsurance?*, Client Value Series Brief No. 1. (Geneva, ILO).
- The Economist. 2012. "Asian welfare states: New cradles to graves", 8 Sep. Available at: <http://www.economist.com/node/21562210> [26 November 2013].
- The Economist Intelligence Unit. 2012. "The future of healthcare in Africa". Available at: http://www.economistinsights.com/sites/default/files/downloads/EIU-Janssen_HealthcareAfrica_Report_Web.pdf [25 November 2013].
- Greyling, L. 2013. *Microcare Insurance Uganda – Case study*, Microinsurance Paper No. 24 (Geneva, ILO).
- Gustafsson-Wright, E. 2013. *A short-term impact evaluation of the health insurance fund program in central Kwara state, Nigeria*. Available at: <http://www.pharmaccess.org/img/A%20Short-term%20Impact%20Evaluation%20of%20the%20Health%20Insurance%20Fund%20Program%20in%20Central%20Kwara%20State,%20Nigeria.pdf> [28 May 2014].
- Holtz, J., Hoffarth, T., Desai, S. Forthcoming. *The Value of Claims Analysis in Health Microinsurance: Learning from Three South Asian Cases*.
- International Labour Organization (ILO). 2012. Recommendation R202 - social protection floors recommendation, 2012 (no. 202) Available at: http://www.ilo.org/dyn/normlex/en/f?p=1000:12100:0::NO::P12100_INSTRUMENT_ID:3065524 [7/2/2013].
- Kimball, M.; Phily, C.; Folsom, A.; Lagomarsino, G.; Holtz, J. 2013. *Leveraging health microinsurance to promote universal health coverage*, Microinsurance Paper No. 23 (Geneva, ILO).
- Koven, R.; Chandani, T.; Garand, D. 2013. *The business case for health microinsurance in India: The long and winding road to scale and sustainability*, MILK Brief No. 26 (Appleton, WI, Microinsurance Centre).
- Koven, R.; Magnoni, B.; Zimmerman, E.; Sobol, D.; Budzyna, L. 2014. *Balancing client value and business case in Kenyan health microinsurance*. Available at: http://www.microinsurancecentre.org/resources/documents/doc_download/1086-balancing-client-value-and-business-case-in-kenyan-health-microinsurance.html [28 May 2014].

Ladusingh, L.; Pandey, A. 2013. "Health expenditure and impoverishment in India", in *Journal of Health Management*, Vol. 15, No. 1, pp. 57–74.

Le Roy, P.; Holtz, J. 2011. *Third party payment mechanisms in health microinsurance*, Microinsurance Paper No. 13 (Geneva, ILO).

Ma, Y.; Zhang, L.; Chen, Q. 2012. "China's new cooperative medical scheme for rural residents: Popularity of broad coverage poses challenges for costs", in *Health Affairs*, Vol. 31, No. 5, pp. 1058–1064.

Mahal, A.; Krishnaswamy, K.; Ruchismita, R.; Babu, B.G. 2013. "What is a health card worth? A randomised controlled trial of an outpatient health insurance product in rural India", *The Lancet*, Vol. 381 (June), p. 87.

Magnoni, B.; Zimmerman, E. 2011. *Do clients get value from microinsurance? A systematic review of current and recent research*. (Appleton, WI, Microinsurance Centre).

Matul et al. forthcoming. [Please add details]

Matul, M.; Dalal, A.; De Bock, O.; Gelade, W. 2013. *Why people do not buy microinsurance and what can we do about it*, Microinsurance Paper No. 20 (Geneva, ILO).

Platteau, J.P.; Ugarte, D. 2013. Understanding and information failures: Lessons from a health microinsurance programme in India, Research Paper No. 29 (Geneva, ILO).

Quinn, S.; Dercon, S.; Matul, M. 2014. "Why and how does impact happen?", in R. Radermacher and K. Roth (eds): *A practical guide to impact assessments in microinsurance* (Luxembourg, Microinsurance Network and Micro Insurance Academy), pp. 41–60.

Rendek, K.; Holtz, J.; Fonseca, C. 2014. *The moment of truth: Claims management in microinsurance*, Microinsurance Paper No. 28 (Geneva, ILO).

Roth, J.; McCord, M.J.; Liber, D. 2007. *The landscape of microinsurance in the world's 100 poorest countries* (Appleton, WI, Microinsurance Centre).

Scheil-Adlung, X. 2013. "Health protection: More than financial protection", in A.S. Preker, M.E. Lindner, D. Chernichovsky and O.P. Schellekens (eds): *Scaling up affordable health insurance – Staying the course* (Washington, DC, World Bank), pp. 13–48.

Shahrawat, R.; Rao, K.D. 2012. "Insured yet vulnerable: Out-of-pocket payments and India's poor", in *Health Policy and Planning*, Vol. 27, No. 3, pp. 213–221.

United Nations. 1948. *The Universal Declaration of Human Rights*, Article 22.

World Health Organization. 2014. *Antimicrobial resistance – Global Report on Surveillance* (Geneva).

Woodman, B; van Bastelaer, T.; Long, D.; Chatterji, M. 2013. *Saving money, saving lives: An inquiry into a micro-savings maternity product in Kenya* (Bethesda, MD, Abt Associates).

Xu, K.; Evans, D.; Carrin, G.; Aguilar-Rivera, A.M.; Musgrove, P.; Evans, T. 2007. "Protecting households from catastrophic health spending", in *Health Affairs*, Vol. 26, No. 4, pp. 972–983.

Zimmerman, E.; Magnoni, B.; McCord, M. 2013. *Beyond the actuary's guess: Lessons from 15 studies on client value of microinsurance* (Appleton, WI, Microinsurance Centre).

Zollmann, J. Forthcoming. *Risks and financial lives of low-income Kenyans*, Microinsurance Paper No. 38 (Geneva, ILO).

Icons used in Figure 6 are by Freepik, Daniel Bruce, SimpleIcon, from www.flaticon.com.

APPENDIX: ILO MICROINSURANCE INNOVATION FACILITY PARTNERS CITED

Name of project	Type of document	More information available at
Aseguradora Rural	Learning Journey Case Brief	http://www.microinsurancefacility.org/projects/lessons/health-and-life-microinsurance-products-banrural http://www.microinsurancefacility.org/publications/cb1
CARE Foundation	Learning Journey	http://www.microinsurancefacility.org/projects/lessons/insuring-primary-care-sustainable-financing
Changamka	Learning Journey	http://www.microinsurancefacility.org/projects/lessons/linda-jamii
Groupe de recherche et d'échanges technologiques (GRET)	Learning Journey	http://www.microinsurancefacility.org/projects/lessons/piloted-health-insurance-garment
Hygeia Community Health Plan	Learning Journey	http://www.microinsurancefacility.org/projects/lessons/hygeia-community-health-information-system
Microcare	Microinsurance Paper Case Study	http://www.microinsurancefacility.org/publications/mp24
Microfund for Women (MFW)	Learning Journey	http://www.microinsurancefacility.org/projects/lessons/pioneering-womens-world-banking-caregiver-policy
Palmyrah Workers Development Society (PWDS)	Learning Journey	http://www.microinsurancefacility.org/projects/lessons/mainstreaming-access-insurance-services
SAJIDA Foundation	Case Brief	http://www.microinsurancefacility.org/publications/cb3
Swayam Shikshan Prayog (SSP)	Learning Journey	http://www.microinsurancefacility.org/projects/lessons/enhancing-ommunity-resilience-low-income
Union des mutuelles de santé de Guinée forestière (UMSGF) and International Centre for Development and Research (CIDR)	Learning Journey	http://www.microinsurancefacility.org/projects/lessons/making-mutuals-ready-mass-market
Uplift	Learning Journey	http://www.microinsurancefacility.org/projects/lessons/bringing-health-insurance-converged-approach
VimoSEWA	Learning Journey	http://www.microinsurancefacility.org/publications/mp25

IMPACT INSURANCE FACILITY

Housed at the International Labour Organization, the Impact Insurance Facility enables the insurance industry, governments, and their partners to realise the potential of insurance for social and economic development. The Facility was launched in 2008 with generous support from the Bill & Melinda Gates Foundation, and has received subsequent funding from several donors, including the Z Zurich Foundation, Munich Re Foundation, the IFC, USAID and AusAID.



International
Labour
Organization


IMPACT INSURANCE

.....
impactinsurance@ilo.org
<http://www.ilo.org/impactinsurance>