Learning Journey

Freedom from Hunger

Health Microinsurance Consumer Education

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Project Basics

About the project

Freedom from Hunger is a not-for-profit organization, founded in 1946 and working in 24 countries in West Africa, Latin America and Asia. Its mission is to bring innovative and sustainable “self-help” solutions to the fight against chronic hunger and poverty. Its core activities focus on working with local partners that include microfinance institutions (MFIs) and non-governmental organizations (NGOs) designing and disseminating integrated financial services and lifeskills training, including microfinance and microinsurance, livelihood development, health protection, nutrition and household food security, and empowerment of women. Freedom from Hunger’s work currently reaches 5.1 million microfinance clients.

Although a diverse set of actors is currently involved in providing health microinsurance (HMI) to low-income people, outreach has been limited, particularly in rural areas. For most low-income people in the developing world, the concept of insurance—to protect against the cost of illness, accident and extended ill health—is new, untested and not well understood. To fill the gap, Freedom from Hunger set out to develop a consumer education module targeted to poor families on how HMI works, the benefits of HMI as part of a strategy to protect family assets from the financial impact of serious illness, and how to access and appropriately use HMI to access quality healthcare services.

In the first phase of the project, Freedom from Hunger designed, developed and field-tested an HMI consumer education programme consisting of short, interactive education sessions called Technical Learning Conversations (TLCs). TLCs are 30-minute group discussions designed to be delivered in small groups and to meet the learning needs of poor women, the vast majority of whom have low levels of literacy. The TLCs use stories, role-plays and visual aids to explore the costs and risks of illness, how health insurance works, what the insurance covers, and how to utilize insurance to access covered healthcare services. An adaptation guide to support the implementation and delivery of the TLCs in other countries and with other health insurance products and schemes was also developed. A research plan to evaluate the impact of the module on a range of changes in consumer health insurance knowledge and behaviors—e.g. enrolment and use of services when needed—was also developed with input from Innovations for Poverty Action (IPA), the research organization that then conducted the research studies.

During Phase 2 of the project, Freedom from Hunger worked with Sinapi Aba Trust (SAT), a Ghanaian MFI, and IPA to complete an evaluation of the effectiveness of the consumer education in a real-world environment. The data-collection and analysis took place over a two-year period in order to assess characteristics of MFI clients who were enrolled and not enrolled in the insurance; changes in insurance knowledge; rate of enrolment or take-up; disenrolment; the ability of consumers to access and use the benefits covered by their policies; and, to look at the relationship between insurance enrolment and use of services, food security and financial shocks.
Project context

A national health insurance scheme (NHIS), administered by the National Health Insurance Authority (NHIA) as well as by local scheme offices, provides a comprehensive set of healthcare services that has been available to the formal and informal sectors in Ghana since 2003. However, coverage is far from universal, especially in rural areas.

Ghana’s NHIS enables individuals in the informal sector to register for health insurance by paying an insurance premium and registration fee (see Table 1) and, after a three-month period, receive a comprehensive set of covered health services for no fee. Pregnant women, children under the age of 18 (of registered parents) and persons age 70 and older are not required to pay the annual premium, but may need to pay a small annual registration fee.

The health services covered by the NHIS are fairly extensive and purport to cover 95 per cent of all health problems reported in Ghanaian healthcare facilities. A prescribed medicines list is also delineated. Expensive, highly specialized care, such as dialysis for chronic renal failure and organ transplants, are not covered by the NHIS. Neither are antiretroviral drugs for the treatment of HIV/AIDS, as these drugs are supplied by a separate government programme.

There is a notable emphasis on female reproductive health in the benefits package. Benefits for maternity care include antenatal care, caesarean sections and postnatal care for up to six months after birth. Treatment for breast and cervical cancer are included in the package, although treatment for other cancers is not.

While the programme has dramatically increased access to healthcare services, there are still a large number of Ghanaians, particularly informal-sector workers and the poorest, who are not registered in the health insurance programme. At the end of 2009, the Ghanaian NHIA, which manages the NHIS, estimated that 62 per cent of the population was registered, with 48 per cent actually having current enrolment. A controversial report published by Oxfam in 2011 suggested that the rate of enrolment was likely to have been much lower and that insurance enrolment rates could be as low as 18 per cent.

During 2010, the NHIA took a closer look at actively enrolled members compared to those who had registered but were inactive as a result of non-payment of the annual premium. They determined that 34 per cent of the population was actively enrolled at the end of 2010. The NHIA estimates of active membership by region showed considerable variation, ranging from a low of 23 per cent in the Central Region of Ghana to a high of 53 per cent in the Upper West. In the Northern Region, the location of SAT’s programme and where the study was located, active enrolment was estimated to be 31 per cent of the population.

While local NHIS offices can set their own registration fees, which usually range from 2–5 Ghanaian cedis (GHC) (US$ 1.32–$3.30), NHIA sets annual premiums. Because fees (and sometimes premiums) vary by NHIS office, the total cost of registering for a year of insurance also varies, but is typically between 11 and 14 GHC ($5.57–$7.22) for adults in the Northern Region. See Table 1 for a list of premiums and fees charged by the NHIS districts serving the project programme participants as of January 2012, as reported to IPA by each district NHIS. Children under 18 are exempt from the premium payment, but usually must pay the registration fee.

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1 National Health Insurance Authority Report, 2009
2 National Health Insurance Authority, Annual Report, 2009
Table 1. Insurance premiums and fees reported by NHIS districts serving clients of the Tamale, Bole, Salaga, and Walewale SAT branches

*All currency in Ghanaian Cedi (GHC; exchange rate as of August 2012 was 1.94 GHC to $1).*

<table>
<thead>
<tr>
<th>NHIS district</th>
<th>Registration fee for adult</th>
<th>Premium for adult</th>
<th>Total cost of registration for adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tolon</td>
<td>5.00</td>
<td>7.20</td>
<td>12.20</td>
</tr>
<tr>
<td>Savelugu</td>
<td>4.00</td>
<td>7.20</td>
<td>11.20</td>
</tr>
<tr>
<td>Tamale</td>
<td>4.00</td>
<td>7.20</td>
<td>11.20</td>
</tr>
<tr>
<td>West Manprusi</td>
<td>4.00</td>
<td>10.00</td>
<td>14.00</td>
</tr>
<tr>
<td>Bole</td>
<td>5.00</td>
<td>8.00</td>
<td>13.00</td>
</tr>
<tr>
<td>East Gonja</td>
<td>2.00</td>
<td>10.00</td>
<td>12.00</td>
</tr>
<tr>
<td>AVERAGE</td>
<td>3.67</td>
<td>7.80</td>
<td>11.47</td>
</tr>
</tbody>
</table>

Once a person registers with NHIS and pays applicable fees and the annual premium, there is a three-month waiting period before the insurance can be used to access healthcare services, except for pregnant women who can immediately access prenatal and maternity care. By the end of the three-month waiting period, individuals are supposed to receive a health insurance card from NHIS that covers a five-year period. In some cases, the card arrives late and people are told to obtain a temporary card from NHIS. The insurance remains in effect for one year, after which the individual must re-enrol and pay the annual premium and applicable registration fees. The annual expiration date is printed on the NHIS card and stickers are added to the card at the time of annual re-enrolment to indicate current enrolled status. However, the onus falls on the client to remember to re-enrol; this poses a particular challenge for illiterate clients who cannot read the expiration date on the card and who may not understand that they need to pay once a year.

After the expiration date, covered individuals have a three-month grace period during which the insurance can be renewed. If an individual fails to re-enrol within that grace period, NHIS policy dictates that the individual must go through another three-month waiting period. At the start of our study, NHIS offices serving the SAT clients in our sample were not enforcing this rule. Rather, they allowed individuals to access care immediately after re-enrolling, even if the policy had expired. If the insurance had been expired for more than one year, clients were required to pay the premium for every year that they had missed in order to use insurance immediately. In 2011, local NHIS officers reported a change in the enforcement of the expiration policy, indicating that if registrants did not pay the annual premium and fees within 90 days of expiration, that they would lose eligibility for services and be required to wait three months to access services once premiums and fees were paid for the year.

When a client’s insurance expires at the end of one year, the client is still considered to be “registered” with NHIS—their information is stored in NHIS databases and if they re-enrol, a new sticker is provided for their membership card that indicates the new expiration date. In order to be considered “enrolled” or “active” and eligible for covered services, the client must be current on the premium payment. If the client fails to pay the annual premium, the client may be termed “unenrolled,” “inactive” or “expired”.

NHIS offices report that re-enrolment is a particular challenge. While registration rates have increased, many of the registered individuals fail to re-enrol each year. For example, in 2010 the Tolon NHIS office,
which serves a rural area near the city of Tamale in Northern Ghana, estimated that about one-half of the population in its district is registered and has a current policy, but another 30 per cent has registered but not renewed their insurance, allowing it to expire. This is consistent with findings from Freedom from Hunger’s sample for its baseline study, in which 70 per cent of the respondents report being registered for insurance but only about 32.6 per cent of the total could be either confirmed as currently enrolled (premiums current) from visual inspection of the insurance card, or through extrapolation based on their reported use and ways of paying for health services.

There are a number of potential barriers to registration and enrolment in the health insurance programme. Individuals may not know about the programme, may not understand how insurance works or what is covered, or may not know how to go about registering. Some individuals may also be unable to afford the premium at the time it is due. While an 11–14 GHC payment is not a particularly high amount even in rural Ghana, a large family may find it a challenge to put together the money to cover every adult household member under the age of 70, particularly at a set time each year, as there is no flexible payment option. Individuals may also believe that insurance is not a good value for them because of lack of availability of providers, benefit limitations, or because they do not think they will need health services, or perceive the quality of services available to be low compared to health care paid for out-of-pocket, or on a “cash and carry” basis. Lastly, individuals may have every desire and intention to register, but simply do not get round to doing it.

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Some of SAT’s groups served by its Tamale branch are located in the areas served by the Tolon NHIS office. People may register at any NHIS office, so the Tolon NHIS office possibly serves some people living within the city of Tamale as well.

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Project Summary

<table>
<thead>
<tr>
<th>Project Name:</th>
<th>Health Microinsurance Consumer Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Start Date:</td>
<td>April 2009</td>
</tr>
<tr>
<td>Duration:</td>
<td>3 years and ten months</td>
</tr>
<tr>
<td>Country:</td>
<td>Ghana</td>
</tr>
<tr>
<td>Product:</td>
<td>Health</td>
</tr>
</tbody>
</table>
Project Updates

Key Performance Indicators

Table 2. Extrapolated enrolment of SAT clients in sample

<table>
<thead>
<tr>
<th></th>
<th>Baseline enrolled clients</th>
<th>Midline enrolled clients</th>
<th>Endline enrolled clients</th>
<th>% change</th>
<th>Baseline enrolment</th>
<th>Midline enrolment</th>
<th>Endline enrolment</th>
<th>Per cent pt change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short</td>
<td>120</td>
<td>158</td>
<td>218</td>
<td>82%</td>
<td>30%</td>
<td>39%</td>
<td>54%</td>
<td>24</td>
</tr>
<tr>
<td>Consolidated</td>
<td>130</td>
<td>172</td>
<td>174</td>
<td>34%</td>
<td>34%</td>
<td>45%</td>
<td>45%</td>
<td>11</td>
</tr>
<tr>
<td>Control</td>
<td>169</td>
<td>207</td>
<td>257</td>
<td>52%</td>
<td>32%</td>
<td>42%</td>
<td>52%</td>
<td>20</td>
</tr>
<tr>
<td>TOTAL</td>
<td>419</td>
<td>537</td>
<td>649</td>
<td>55%</td>
<td>33%</td>
<td>42%</td>
<td>50%</td>
<td>17</td>
</tr>
</tbody>
</table>

These data show Freedom from Hunger’s best estimate of the enrolment status for all of the individuals in the sample from baseline to endline. Since clients who reported that they were registered could not always show ID cards, this data is extrapolated using the percentages of clients who reported they were registered, could show cards, or whose enrolment could be verified. This percentage was then applied to the number of people who reported that they were registered but could not show their insurance cards. Although differences across groups are not statistically significant, even controlling for initial enrolment rate, the number of individuals enrolled in the SAT groups increased by 55 per cent over the course of the study. When looked at from the perspective of total penetration or uptake, the percentage of SAT clients in the sample who were enrolled went from 33 per cent at baseline to 50 per cent at endline.

What has happened?

April 2009–March 2010: Product development; partner identification; field test

Freedom from Hunger started with research to identify consumer education materials currently being used with HMI, and discovered that few tested and applicable materials existed. Using well-tested principles of adult learning, Freedom from Hunger designed the TLCs to be easily delivered by MFIs or NGOs providing financial services using the following six sessions:

- Costs and risks of illness
- How insurance works
- Advantages of health insurance
- Health insurance available to you
- Using your health insurance
- Deciding to enrol
In addition, a seventh session, “Re-enrolling in health insurance,” was developed to be tested for use at the re-enrolment period.

Work began to identify a suitable partner to field-test and revise the education materials. Despite best efforts, a partner could not be found in Latin America, the intended region. By broadening the scope of its search to India and Africa, Freedom from Hunger identified a suitable partner in Ghana—SAT, a well-established MFI with about 100,000 microfinance clients. Additionally, although Freedom from Hunger hoped to work with a private HMI product because it was thought to be more broadly applicable, it again struggled to find a suitable option. The HMI product that is available to the SAT clients is a public one, the Ghana NHIS, and the education focuses on the features of this scheme.

The field test was completed in early February 2010 in Tamale, a poor agricultural region in northern Ghana with low education and health indicators. Freedom from Hunger trained local SAT financial services staff to deliver the TLCs during the field test using role-plays and other interactive exercises, and observed ways to improve each session’s content and delivery. The module was tested over three days, with three groups of about 16 clients participating in two half-day sessions each. The field-test participants were women and were mostly illiterate. The sessions were conducted outdoors in the usual meeting place for one of the groups. During the field test, Freedom from Hunger staff could closely observe and assess the appropriateness of both the content and the methods used to accomplish the learning objectives for each session. The test yielded important findings regarding several aspects of the NHIS product and the local context for SAT clients, and the most salient gaps in client knowledge about the insurance. These findings were used to modify and improve the content and visual materials in the final module for use in Ghana, and to inform the development of the adaptation guide.

During the field test, new information revealed opportunities for product testing that also expanded the scope of the planned demonstration and evaluation. First, the field-test team discovered that it was not uncommon for clients to have enrolled in the insurance at some point in the past but to have failed to pay their premium the following year, and some were unsure of their status. The problem with re-enrolment was also verified by the local NHIS offices and is a common issue with health insurance for the informal sector. As a result, Freedom from Hunger decided to add a follow-up session to be offered about one year after the initial education was delivered to support re-enrolment in the insurance. Secondly, the team learned that SAT could also provide education in single “one-off” sessions. Since other MFIs had identified challenges in delivering multiple short sessions, the idea to also test the impact of a single intensive training session emerged.

Photo by Louis Jouve (2010)
September 2010: Product refinement; preparation for demonstration; baseline study and education roll-out

Following the field test and further assessment of SAT’s capacity and interest in partnering for the broader demonstration, Freedom from Hunger and SAT agreed to proceed with demonstrating the education in the Northern District, to include branches in Tamale, Salaga, Walewale and Bole. Freedom from Hunger and IPA developed a research design based on a randomized control placement of the education treatments and applied for additional funding from two other funders to support more extensive research on the impact of the insurance on client health and financial status. The randomized control trial (RCT) was designed to look at the impact of several variations of the health insurance education on knowledge about health insurance, enrolment, renewal and the ability of clients to access health services.

The product variations that were tested included the following:

- No education (control)
- Education in six 30-minute sessions, with and without a 30-minute refresher session prior to the annual renewal
- Education in one intensive 2.5-hour session, with and without a refresher prior to the annual renewal

During this time, several challenges arose. First, following the field test, one or more branch managers of SAT did not understand that they should refrain from promoting NHIS enrolment until the demonstration test, and instead proceeded to encourage or even require new loan clients to enrol in the NHIS prior to the delivery of the education. This created the risk of “spoiling” the baseline of active or current HMI enrolment of the target population, which was estimated to be about 10 to 20 per cent.

Secondly, in September 2010, it was learned that a previously announced plan by the current Ghanaian government to change the annual premium for the NHIS to a one-time lifetime premium seemed to be gaining momentum in the Ghanaian parliament, and there was considerable news media coverage. This caused Freedom from Hunger and its partners to carefully assess the potential impact of the change, and the probability of it occurring.

Thirdly, it became apparent that obtaining data on healthcare utilization and enrolment from the NHIS would be problematic due to concerns about data confidentiality, limited staff within NHIS to support such sharing, and overall poor data quality. This information, which was expected to influence the perception of value (and hence enrolment and renewal) by clients would need to be captured through a greater reliance on self-reporting by clients and, therefore, needed to be incorporated in the design of the research to optimize findings and lessons from the demonstration test.
In response, Freedom from Hunger and IPA decided to implement an individual census approach for the baseline survey, in which individuals were asked about their enrolment and, when possible, enrolment was verified with visual inspection of enrolment cards. (See the baseline survey and baseline survey biometrics for more information.) Because clients were sometimes not sure they were enrolled, questions were embedded in the survey that would enable further verification and crosscheck of enrolment status (e.g. asking how certain health services were paid for). Additional questions were also added to query clients about the use and types of services and methods of payment. This longer survey and more cumbersome process to obtain and verify enrolment data added time and cost to this part of the research.

During September and October 2010, the baseline survey was carried out by IPA field staff, trained and supported by IPA. A sample of five clients from each of 300 randomized credit groups was selected to participate in in-depth interviews lasting approximately one to two hours.

**October 2010: Education roll-out with enrolment; knowledge study and baseline survey; first take-up study**

The roll-out of education to treatment groups comprising 60 per cent of 1,500 households from SAT credit groups started in October 2010 and was completed in March 2011, nearly two months later than expected. This was due to challenges with identifying and contacting active credit groups within the sample. Other challenges were also experienced along the way. Specifically, while it had been initially believed that credit groups met every two weeks, in fact some only met monthly, making it difficult to schedule the planned set of six biweekly education sessions. In some cases, the monthly meeting was in reality limited to a meeting between the group leader and the credit agent to hand over loan payments. Freedom from Hunger and IPA convened a high-level problem-solving meeting with the SAT director for microinsurance, the regional supervisor and branch managers, to assess and develop plans to complete all of the education for the treatment groups by the end of February.

In addition to the education, the plans included the administration of the post-education knowledge survey and field enrolment visits for NHIS agents.

Initially the goal was to complete education and promotion of the insurance by the end of November to line up with the post-harvest season and a time when household cash seemed more likely to be available. The delay and unevenness in the roll-out of the education described above, the longer time required to complete the baseline survey, and some delay for year-end holidays, pushed the education completion date back to March (the beginning of planting season), which may have had a negative impact on enrolment because of the local seasonality of income.

An Adaptation Guide, designed to enable other MFIs, NGOs and insurance providers to use the education in other settings, was completed in January 2011.

**April 2011–October 2011: Analysis of baseline and knowledge studies; first uptake survey**

Freedom from Hunger was successful in obtaining additional funding to support a short midline and comprehensive endline survey to assess the impact of the education on insurance uptake, use of health services, health spending, and the impact on the health and financial status of MFI clients.
In March 2011, data was collected to assess the impact of the education on knowledge of insurance with a knowledge survey quiz. An uptake study (which was much shorter than the baseline study) was conducted from July to August 2011. A Final Baseline Report and an Analysis of Knowledge Study were published in September 2011. At this stage findings related to the Knowledge Survey indicated that clients had a relatively high level of starting knowledge, awareness and positive attitudes about the insurance (at baseline). However, findings from the Knowledge Study administered by the SAT financial services officers following the education suggest a positive impact of education on insurance knowledge:

- Clients who received education scored significantly better on the questions that assessed insurance knowledge than those who did not receive education (control)
- Clients in the treatment groups had a significantly greater improvement in insurance knowledge than those in the control groups
- There was not a significant difference between the short session and consolidated session groups with respect to correct answers to knowledge questions
- There were no significant differences between those who received education and those who did not with respect to having generally favorable attitudes towards insurance

Findings from the baseline study related to insurance registration and enrolment into NHIS include the following:

- **Demographics**
  - At the time of the survey, 57.4 per cent of the clients in the sample were estimated to not be actively enrolled in NHIS, with 32.6 per cent enrolled; another 9.9 per cent may have been in the three-month waiting period
  - Individuals with any level of education are more likely to be registered than those with no education at all. Individuals in rural areas are less likely to be enrolled
  - Among clients who reported that they had not registered for insurance, clients in the treatment groups were significantly more likely to say that the reason was that they had not had time to do it (as opposed to reporting that cost or other barriers were reasons for not registering). The second most prevalent reason given for not enrolling was the premium cost
- **Finances and shocks**
  - Findings related to income and consumption suggest that premium payments are not a significant barrier to enrolment
  - Registration for insurance is correlated with a lower probability of a food-insecurity event, or removing a child from school for financial reasons. There was no corresponding correlation for either item with enrolment
- **Health events**
  - While registration and enrolment were not correlated with likelihood of getting treatment, they had a significant relationship to which type of treatment was sought—there was a greater likelihood of consulting a doctor and a decreased likelihood of consulting a chemical seller (drugstore)

Individuals who were enrolled in insurance were more likely to have attended a preventative care visit in the past month. In October, preliminary results from the first uptake survey were made available and a final report provided in March 2012. Overall, the entire sample showed a 30 per cent increase in enrolled clients from baseline to first uptake, and an 11 per cent increase in registration. Enrolment numbers reflect clients who are actively enrolled with up to date premium payments. Registration
numbers reflect clients who have registered and who may or may not be up to date with their premium payments. Some surprising results were obtained, as can be seen in Table 3 below:

**Table 3. Results from uptake survey**

<table>
<thead>
<tr>
<th>ENROLLED Treatment groups (clients)</th>
<th>Baseline</th>
<th>Uptake</th>
<th>Change</th>
<th>Percentage change</th>
<th>Penetration baseline</th>
<th>Penetration uptake</th>
<th>Per cent pt change</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHORT</td>
<td>128</td>
<td>154</td>
<td>26</td>
<td>20</td>
<td>30%</td>
<td>36%</td>
<td>6</td>
</tr>
<tr>
<td>CONSOLIDATED</td>
<td>134</td>
<td>181</td>
<td>47</td>
<td>35</td>
<td>33%</td>
<td>45%</td>
<td>12</td>
</tr>
<tr>
<td>CONTROL</td>
<td>169</td>
<td>224</td>
<td>55</td>
<td>33</td>
<td>32%</td>
<td>45%</td>
<td>13</td>
</tr>
<tr>
<td>TOTAL</td>
<td>431</td>
<td>559</td>
<td>128</td>
<td>30</td>
<td>32%</td>
<td>41%</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REGISTERED Combined treatment groups (clients)</th>
<th>Baseline</th>
<th>Uptake</th>
<th>Change</th>
<th>Percentage change</th>
<th>Penetration baseline</th>
<th>Penetration uptake</th>
<th>Per cent pt Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHORT</td>
<td>302</td>
<td>327</td>
<td>25</td>
<td>8</td>
<td>71%</td>
<td>77%</td>
<td>6</td>
</tr>
<tr>
<td>CONSOLIDATED</td>
<td>287</td>
<td>320</td>
<td>33</td>
<td>12</td>
<td>71%</td>
<td>80%</td>
<td>8</td>
</tr>
<tr>
<td>CONTROL</td>
<td>349</td>
<td>399</td>
<td>50</td>
<td>14</td>
<td>66%</td>
<td>75%</td>
<td>9</td>
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<tr>
<td>TOTAL</td>
<td>938</td>
<td>1,046</td>
<td>108</td>
<td>11</td>
<td>69%</td>
<td>77%</td>
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For enrolled clients, the greatest increases were observed in the control and consolidated or long-session education groups, and the lowest increases were in the groups that received the short-session education. Similar results were seen in the registered clients. None of these differences were statistically significant.

Providing treatment to all groups initially assigned to receive treatment proved to be a challenge. In Bole, Salaga and Walewale, about 19 client groups were assigned to receive the consolidated sessions, and 19 client groups were assigned to short sessions; in Tamale, twice that number were assigned to each of the treatment groups. However, monitoring by IPA suggested that a number of these groups did not actually receive the education. Once the initial data from the uptake was analyzed and the lack of effect observed, IPA and Freedom from Hunger determined that to fully understand the results, better measures of which groups actually received treatment were required. IPA worked with SAT to interview the loan officers who implemented the education to capture information on which groups actually received the education. Agent recall was checked with additional quick interviews of clients and judged to be fairly reliable.

As expected, there were large differences in treatment rates across branches. In two branches, nearly all groups assigned for treatment received it. In one other branch, most of the short-session treatments were provided, but fewer of the consolidated-session treatments. And in the third branch, where more groups were assigned, treatment had the lowest implementation rate; only one short-session group received five or more of the six short sessions.

To further understand whether there were differences across groups assigned to treatment who either got no or only partial education, the data were then disaggregated to the level of the credit group and credit agent and analyzed to look for differences in enrolment and registration. However, the registration and enrolment variables again did not show significant differences between treatment and control groups, or for those individuals in the treatment group that SAT reported actually received treatment as compared to all individuals assigned to the treatment groups.
The final endline uptake survey was planned to take another look at the outcomes analyzed in this report, as well as a range of additional variables related to health and financial outcomes. In addition, the survey would include a qualitative component, aimed at helping understand why individuals do or do not sign up for insurance.

January 2012–April 2012

Freedom from Hunger provided a refresher training to SAT staff in January 2012 to prepare them to deliver follow-up reminder sessions to their clients. The reminder sessions were designed to be administered about a year after the initial education to review the information taught in the initial sessions and to remind clients that after a year they must re-enrol in insurance to maintain active enrolment status and be able to access covered health services. Half of the groups who received initial education were scheduled to receive the reminder sessions, enabling comparison of outcomes between groups that got initial education plus reminder sessions and groups that got initial education but no reminder sessions.

Meetings were also held with management to provide feedback about the lack of consistent and complete delivery of the initial education and to encourage greater monitoring. SAT was asked and agreed to conduct the reminder sessions during February, and monitoring reports and systems were put in place with incentives for prompt reporting of the status of education delivery and completion of the education to the assigned groups. However, by the end of February IPA and Freedom from Hunger became aware of a major staffing change in Tamale, the largest branch in the region. SAT management indicated that the entire branch staff (manager, credit agents and support staff) had been “transferred” and that another branch manager at one of our sample branches had been dismissed because of irregular activity. A new branch manager was assigned to Tamale, an individual who had participated in all of the Freedom from Hunger trainings for SAT and was knowledgeable about the importance of the study and the research design. These staffing and management changes delayed the completion of the delivery of the refresher sessions until early April.

May 2012–September 2012: Endline Survey and Qualitative Study

The endline survey and qualitative studies using focus groups were completed during May and June.

The midline and endline data on insurance enrolment found no significant differences in health insurance enrolment rates between the treatment groups and control group. (See Table 1 for final estimated enrolment numbers.) In addition, there were no significant differences in enrolment rates between those who received reminder sessions and those who did not. The results of the knowledge test administered after the initial treatment sessions suggest that the education did improve knowledge among those who received treatment; however, by the time of the endline (conducted over one year later) there were no significant differences in insurance knowledge across treatment and control groups.

The education may not have had a large impact because baseline knowledge of insurance was already high, suggesting that knowledge was not a barrier to enrolment. Rather, it appears that convenience of registration and a tendency to put off the decision to enrol despite understanding benefits of doing so, and the availability of cash at the time of making premium payments are more important barriers to enrolment and re-enrolment. In addition, the treatment was not implemented with all groups assigned to receive it, and enrolment rates were already relatively high in the sample (32.6% vs. about 20% in the local area) at the beginning of the study. These factors made it more difficult for the treatment to have
an impact large enough to be statistically observable. The high enrolment, high knowledge about insurance, and incomplete implementation were unique factors that suggest this study may have limited external validity; in environments where knowledge and enrolment are low, educational programmes may have more impact.

While there were no significant differences in enrolment rates between the treatment and control groups, respondents’ enrolment increased notably over the course of the study, at a rate that appears to be much greater than the increase in enrolment in the general population in the areas where the study was conducted (a 50 per cent increase in the sample compared to 14 per cent increase locally). While activities of the NHIS aimed at increasing enrolment likely account for some of the increase, it is also possible that the repeated surveys, the checking of cards and expiration dates by surveyors to collect enrolment status, and the education sessions, might have together served as “touch points” that prompted clients to take action to register or enrol in insurance.

Having insurance was not associated with a higher likelihood of getting treatment in the case of health events, but those with insurance were more likely to go to doctors, while those without were more likely to go to less highly trained chemists. Those with insurance also incurred somewhat lower out-of-pocket costs for an incident of illness, and were more likely to have attended a preventative care visit. Although no causal link can be established, being registered in insurance is associated with a lower likelihood of food insecurity, a lower likelihood of removing children from school for financial reasons, and a lower likelihood of selling assets to get money.
Project Lessons

On setting up a consumer education module

Certain key messages about HMI resonate better with low-income clients; pilot-testing is a good way to test and improve these messages. For example, during the field test, Freedom from Hunger observed that low-income households may place more value on the range of insurance benefits to enable them to access needed care and reduce the total costs related to illness, and place less value on insurance as a mechanism that helps prevent illness or promotes health. (Note that the NHIS covers consultations and prenatal care.) Specifically, they learned that an important message to stress to consumers is that the cost of illness includes lost opportunity to generate income.

Lessons on how insurance works must be simple and minimize the use of insurance terminology. The focus should be on general advantages one might gain from the ability to access care when needed (in this case without cash in hand) and the financial protection afforded by the HMI (such as ability to work, no need to borrow money from friends and family and financial security).

It is potentially beneficial to reinforce messages about the benefits of HMI when re-enrolment occurs. In the field test, Freedom from Hunger observed that some clients who had HMI did not use it, were not sure of its benefits, or had discontinued making annual premium payments after initially enrolling at some time in the past. Thus it was observed that there was a need to also provide education about the requirements and process to re-enrol before the re-enrolment period.

Consumer education tools must be flexible; the development process should allow for adaptation and include field-testing. Freedom from Hunger has developed consumer education materials in a number of settings, and the experience in Ghana with the NHIS product has confirmed the importance of using an iterative and structured process that incorporates a range of considerations, such as the existing knowledge base of the population, language, culture and customs. The features of the product and how it works on the ground must also be reflected. As Freedom from Hunger gained a greater understanding of the features and functioning of the NHIS, coupled with understanding of the knowledge and perceptions of prospective enrollees, it was able to refine the education tools and approach.

Insurance product enrolment, and by extension interventions such as consumer education, should be timed to coincide with availability of discretionary income. The average annual premium and fees of about $12.00 for an adult to enrol in the NHIS product, while low, is reported as a challenge for low-income persons to pay, especially when multiple family members need to be enrolled. Since many of the target clients in this region in Ghana have income-generating activities that are tied to agriculture, their total annual income varies by season, depending on cycles for planting and harvesting crops. Targeting enrolment outreach for times when cash may be more available can help, although it may not completely address the challenge of having sufficient cash on hand to enrol larger families. More flexible payment arrangements or simple financing such as small additional amounts added to MFI client business loans (“top-ups”) and savings schemes similar to “sou-sou”s (informal savings groups) are other possible ways to address this enrolment barrier.
Implementing field partners, such as MFIs, need to be carefully informed about how to participate in a randomized control study, and monitored. Because one or more managers of SAT did not understand that they should refrain from promoting NHIS enrolment until the demonstration test, and instead proceeded to encourage or even require new loan clients to enrol in the NHIS, Freedom from Hunger had to quickly react to mitigate the risk of a “contaminated sample”. Freedom from Hunger, SAT and IPA assessed the impact using group census data and determined that the study population was still suitable for the demonstration test and that no material changes to the population sample or study design would be required.

Surveys for rigorous impact studies are best implemented by an objective, trained third party. Although trained surveyors add cost to a study, it can be a worthwhile investment. Although most of the data collected for this study was done by trained surveyors working under close supervision of the research partner (IPA), Freedom from Hunger decided to ask its MFI partner to conduct post-education knowledge tests. Despite best intentions, the field support of the MFI partner to conduct the sampling and data collection according to defined rigorous standards broke down in several cases. Only 155 of 600 surveys were completed, and without adherence to the rules to maintain randomization. Finally, the field staff may inject an unintended bias to report positive change, thinking this will reflect positively on them or their clients. All of these consequences have implications on the quality of the research, and hence the confidence that can be placed in the final results for the knowledge-change information.

On the impact of a consumer education module—uptake, retention, access and use

Gaps in knowledge existed, but may not have been the biggest barriers to enrolment. During the field test, it was found that overall knowledge of the insurance was quite high. Although the education seemed to improve some knowledge gaps immediately after the sessions, lack of knowledge may not have been the biggest barrier to enrolment. Clients reported that the main reasons they had not enrolled or re-enrolled were related to affordability, and that while they had intended to enrol, they had just not got round to doing so. Further inquiry during focus-group discussions as well as the analysis of data on the correlation between income, expenditures and enrolment indicated that the affordability issue was most likely related to the availability of cash to pay premiums when needed. Most clients feel that the insurance is a good value.

Operating practices of a scheme can have unintended effects on enrolment and use. The process to register for five years, which has a three-month initial waiting period, plus an annual premium payment that is required to maintain active enrolment status, is difficult for clients to understand and track. Further, our experience in north Ghana indicated that for some time the operating policies varied and this likely created even more confusion for clients.

Registration and enrolment in the NHIS encourages use of doctors in place of chemists, and encourages use of preventive care. Because the NHIS only covers prescriptions made by medical doctors, enrolled clients are more likely to visit doctors than chemists. This difference in health-seeking behavior, while perhaps increasing overall costs, may also lead to better quality of care or improved outcomes, although this is as yet unproven. Enrolled clients were also more likely to have received preventive consultations.
On project set-up

The selection of an implementing partner and an HMI scheme to pilot-test an intervention such as consumer education should be well-structured and carefully considered.

Freedom from Hunger established and followed several criteria for selecting a test site and partner:

- Scheme had to be operational, stable, and with a membership of at least several thousand; ideally it will be a private-sector product
- Product had to be appropriate for the poor, i.e. the coverage is appropriate for the risks faced by poor consumers, the product is simple to understand and access, and the premium is affordable (or perceived to be)
- Adequate access to acceptable healthcare providers
- Distribution partner capable of reaching MFI clients, self-help groups or other organized groups with education

Based on the overall experience of working with SAT in the field test, including staff training, Freedom from Hunger thinks that the upfront effort and extra time to select a partner was a worthwhile investment, and that even more scrutiny of the organization at the level of local operations would have been well-advised. SAT came to the project with enthusiasm for linking more of its clients to health insurance, and with pre-existing capacity for training and delivery of education. Non-financial services such as education were reported by SAT senior management as being an integral part of its mission and goal to improve the lives of its clients. However, a number of challenges emerged later in the project. Randomized control study design requires extra effort on communication. Furthermore, researchers must be able to identify and access clients for baseline interviews. A capacity to maintain the research protocols throughout the process is also vital to protect the integrity of the design and reliability of the findings.

Freedom from Hunger’s consideration of potential partners would have benefited from closer examination of the operations of the MFI at the level of the operating branch in the area where the study was to be launched. In particular, after the fact, Freedom from Hunger discovered that repayment issues as well as management challenges were occurring in one of the branch offices where the study was conducted. Although it is unknown how discoverable these would have been prior to the study, it is a lesson for future efforts that are intended to demonstrate and evaluate a specific intervention. On the other hand, since interventions such as health insurance education, or even the introduction of new health insurance schemes, will always need to work in the “real” world, the challenges at SAT with ensuring uniform programme roll-out and data-collection are not atypical of those that will be present in further replications.

Plan adequate time to identify pilot-test sites with an existing health microinsurance product and a capable implementing partner. In hindsight, the time frame established by Freedom from Hunger for finding a suitable local partner, product and target market following project kick-off was overly optimistic. In reality, the field of HMI is still nascent, with limited availability of appropriate and affordable commercial products, and while MFIs are perceived to be a viable and promising distribution
channel, the real numbers of those who are actively promoting and offering appropriate products is still quite small.

**Working with public health insurance programmes can mean unforeseen challenges due to shifting government policy and changes in financing, management or infrastructure issues.** A private HMI product would have been ideal, since in theory data would be more readily available for enrolment and claims, and results could be more transferable to other schemes, but this turned out to be an additional constraint that ultimately had to be relaxed. Given that the product being tested is Ghana’s NHIS, enrolment in the scheme heavily depends on the financial subsidy of the premium, how the government manages the scheme, and the quality of the healthcare providers and services. It is also subject to the effects of any changes in government policy with respect to premium payment, eligibility, and covered services. For example, due to political and financial events, midway through the study the Ghanaian government indicated its plan to restructure the annual premium of $8 to $9 to a single lifetime premium, which would likely cost several times more. Although in the end this change was not implemented during the study period, news reports of its imminence could have affected enrolment decisions and fueled ongoing confusion among those eligible regarding the costs and terms of insurance.

Additionally, access to claims and enrolment data was blocked due to government rules, concerns over confidentiality, lack of resources, and administrative bottlenecks to enrol members and process claims. During the time of the study, the NHIA was operating with delays of more than three months to issue identification cards, and had claims backlogs of six months or more.

Finally, the National Health Insurance Fund (NHIF) operates with a complex system of registration (valid for five years) coupled with annual enrolment and premium payment (except for children, pregnant women and people over age 70); there is an initial three-month waiting period, and often identification cards are delivered after the effective date, leading to considerable confusion on the part of clients as to whether, and when, they are actively enrolled.

**Findings of lack of impact, while disappointing, can still be helpful towards the overall goal of understanding barriers to insurance take-up and to inform future strategies to improve enrolment of poor families.**

While it is undeniable that our findings at midline and endline were disappointing, they should not have been entirely surprising given the unexpected findings of high levels of insurance knowledge, awareness and positive attitudes about the insurance at baseline. There were many contextual factors at work in Ghana and with the implementation that quite likely limited the project’s ability to completely evaluate the value and contributions of the education. These are discussed in great detail in the research report. Further, the education module improved knowledge (even at already high levels). These findings do not lead to the conclusion that the module would not improve enrolment in other contexts.

The findings of high initial levels of knowledge, along with the results from midline and endline, surfaced an important follow-up question: If knowledge was not the barrier to greater enrolment, then what was? As a result, a qualitative study component was incorporated into the endline quantitative study. This involved adding some qualitative questions to the survey about why people were not enrolled, as well as focus groups with clients. It was this process of inquiry that enabled Freedom from Hunger to reach important conclusions about the most important barriers in this setting: the availability of cash on hand to pay premiums when needed and the failure to enrol despite intending to do so.
Sharing Results and Examining Implications

Key findings and implications for continuing to find ways to increase health insurance coverage of poor families have been presented and discussed in two separate forums, as detailed below.

The first was a knowledge sharing forum organized by the ILO’s Microinsurance Innovation Facility in India in September 2012. A complete report of that workshop can be accessed here, including a summary of lessons learned and a presentation. The reaction and conclusion of the forum participants was that despite lack of evidence of effect from Freedom from Hunger’s study, as well as that of a study from another researcher, we should not abandon education as an important strategy to improve levels of health insurance coverage and the value of that coverage for the poor. Participants argued that uptake alone may not fully evaluate the worth of education; that education was still likely important for its potential to change health behaviors, to empower poor clients, and as a long-term investment. They identified the need for more longitudinal studies and for additional ideas for how to conduct effective campaigns at scale.

The second event was a dissemination workshop organized in Tamale, Ghana in January 2013, attended by over 40 individuals representing MFIs, NGOs, associations, researchers, the NHIS and the NHIA. The workshop was a successful forum for sharing and discussing the implications of the study on health insurance enrolment and re-enrolment of microfinance clients in the NHIS. Our overarching goals were 1) to identify and understand ongoing barriers to greater NHIS enrolment (and re-enrolment) of clients of organizations that provide financial services to poor families (MFIs, rural banks, credit unions and NGOs) and 2) to articulate opportunities, strategies and specific next steps for increasing active enrolment of these clients.

The workshop plenary, discussion and small working groups charged with defining barriers and solutions generated the following key observations and recommendations:

1. The study showed evidence of benefits to clients of financial services providers (FSPs) who were enrolled in the insurance. These included reduced vulnerability to financial shocks and food insecurity and greater access and use of health services, including preventive services. These client benefits also support the mission and performance of FSPs by increasing risk protection of clients and loan portfolios, and improving social performance.

2. The NHIA and NHIS can benefit from harnessing the outreach capacity of FSPs to enrol and maintain active enrolment (re-enrolment) of their clients in the NHIS. Research findings showed that overall, when the studied MFI engaged with clients by providing education and asking and checking client enrolment status, total enrolment of MFI clients increased 55 per cent during the intervention, as compared to an estimated 14 per cent increase in overall NHIS active enrolment in the local areas where the MFI was operating.

3. Although there was no relationship detected between enrolment rates of those clients who received education and those who did not, most participants in this workshop indicated that education and outreach to change attitudes and to target re-enrolment is important, should be continued, and should specifically target re-enrolment.
4. There was unanimous interest and strong support in developing more strategic partnerships between the FSPs and NHIA/NHIS that would establish FSPs as agents to enrol, re-enrol, collect and remit premiums, and to ensure that enrolled individuals have ID cards.

Subsequent to this workshop, and the sharing of a report with all participants and other stakeholders who could not attend, two meetings have been held with representatives from the GHAMFIN (Ghana Microfinance Network) and the NHIA to further validate interest in developing more formal partner-agent agreements between the NHIA and MFIs and community banks in Ghana. While it is not clear at the time of preparing this final learning journey whether there will be sufficient resources for the necessary technical support, it is clear that the workshop has created new interest and momentum for a private-public partnership between the NHIA and Ghanaian MFIs. If successful, this effort could facilitate the enrolment of millions of additional poor families into the scheme.