Proliferation & Penetration of Micro Health Insurance:
A Few Lessons

Expert Group Meeting: Innovative Finance for Sustainable Development
United Nations, New York – October 19,2007

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Agenda

- Why Micro Health Insurance
- MHI : An Overview
- Putting things into Perspective
- Hurdles to Growth
- Our Strategy
- Sustainable good practises
- Creating a Facilitative Environment

Risks Faced By The Poor

- Low Income households are exposed to
  - Risks and Income Shocks
- Idiosyncratic risk
  - Sudden unexpected shocks that temporarily dis generate income
    - **Health events**
    - Life cycle events: Marriage, Death
    - Enterprise risks
- Systemic risks
  - Weather variations
  - Natural calamities
  - Crop failures
  - Price fluctuations

Poverty and Vulnerability reinforce each other in an escalating downward spiral

MDGs would be more achievable with greater penetration of social protection

Informal Mechanisms of Risk Mitigation

Self Insurance

- Draw upon savings
- Distress sale of produce/assets
- Shift to non-remunerative crops
- Change of vocation
- Leads to credit at higher interest rates

Community Insurance

- Community insurance schemes best suited for idiosyncratic risks of limited capacity
- Risk funds
- "gifts' to neighbors and kinship groups

Government Support

- Calamity relief
- Subsidies
- Minimum Support Prices

India has an alarmingly low penetration of insurance at premium being only 2.9%of overall GDP

Issues in Health Financing in India

- Public health spending has declined from 1.3 % (1990) to 0.9 %(1999) of the GDP
  - Lack of basic health infrastructure
  - Limited availability of manpower in rural areas
- Private health care spending stands at 4.2% of GDP
  - Large population availing private health care
  - Majority of such health care is out-of-pocket expenditure
  - This has high adverse effect on the poorest of the poor

Issues of Health Financing in Africa

- **About 80% of nurses from Liberia and an equal number of doctors from Mozambique are working industrial countries**
- **High Job vacancy / Attrition rates in Public Health Systems in Ghana, Zambia and Zimbabwe are all attributed to Migration**
- **Over 20% of Sub- Saharan Africa's population over the age of 15 with a posts secondary education works in OECD countries compared with less than 10% in South Africa**
- **Some countries expatriation rates exceed 50% of Educated population**

  "As the population of developed countries are aging and coming to require more medical attention they are sucking away local health talent from developing countries…"

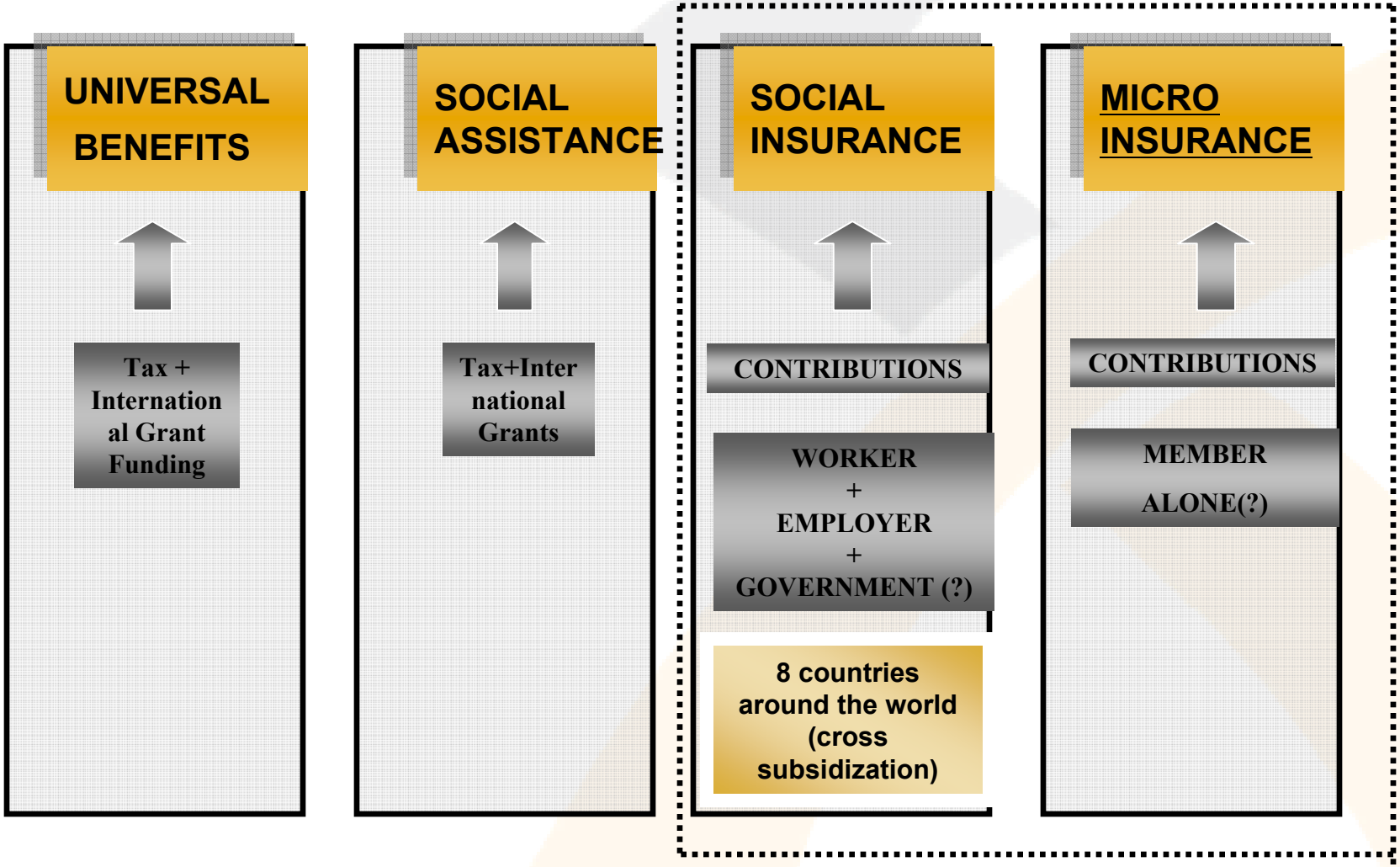
- **US Journal of American Medical Association (JAMA) reported that 1 of 5 practicing medical practitioners in US are trained abroad…**

If the practice continues by 2020- US could face a shortage of up to 800,000 nurses and 200,000 doctors

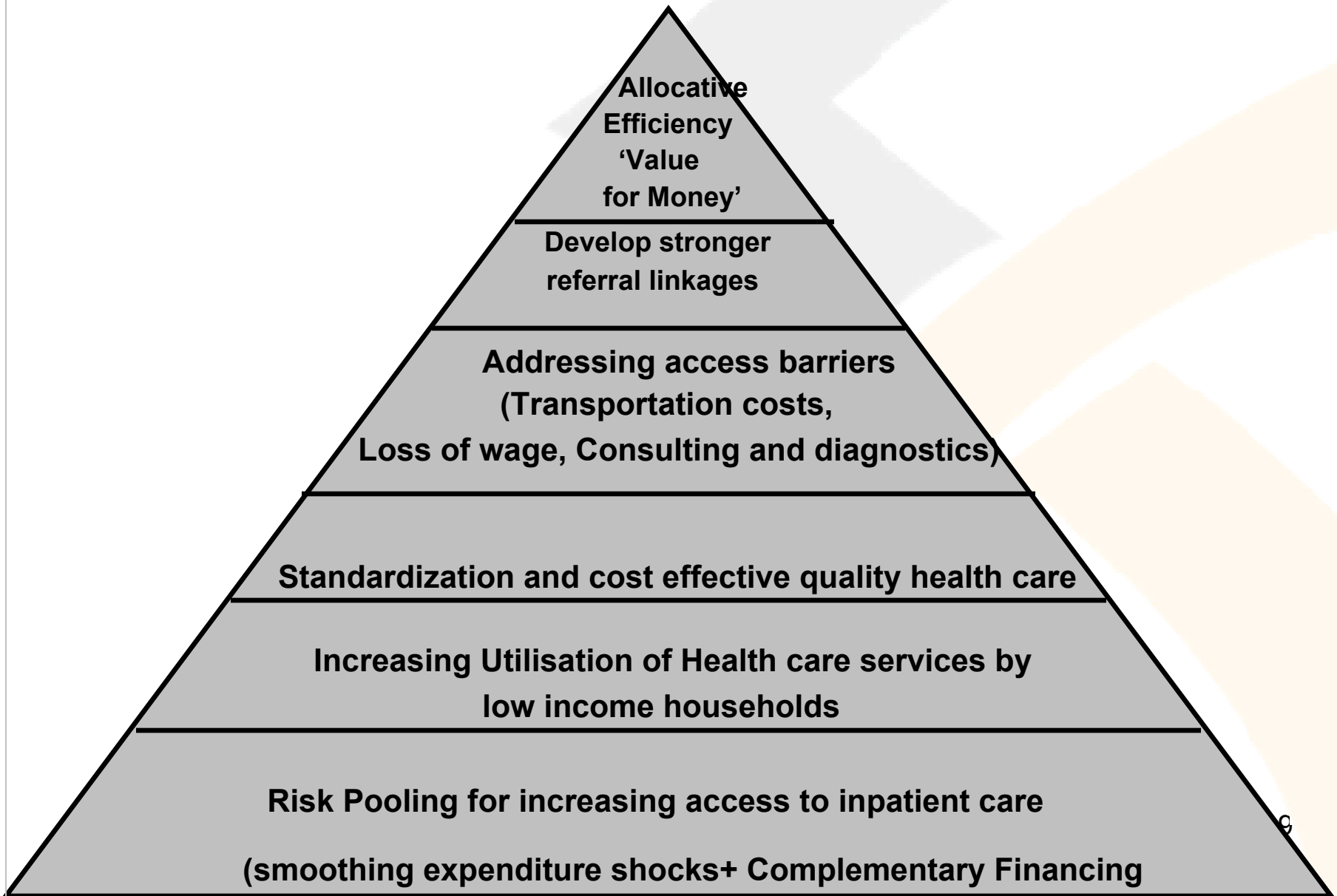
Why Micro Health Insurance
A right based approach?

- Under ILO's Definition, nine major benefits should be covered under Social Security:
  - **Medical Care,**
  - **Sickess Benefits**,
  - Unemeployment Benefits,
  - Old age benefits,
  - **Employment Injury Benefits,**
  - Family Benefits,
  - **Maternity Benefits,**
  - Invalidity Benefits, Survivors Benefits
- MHI is a safeguard against rising medical costs
- Impact on poverty 'Multiplier Effect'

Social Security Benefits: Who pays?



Measuring Success



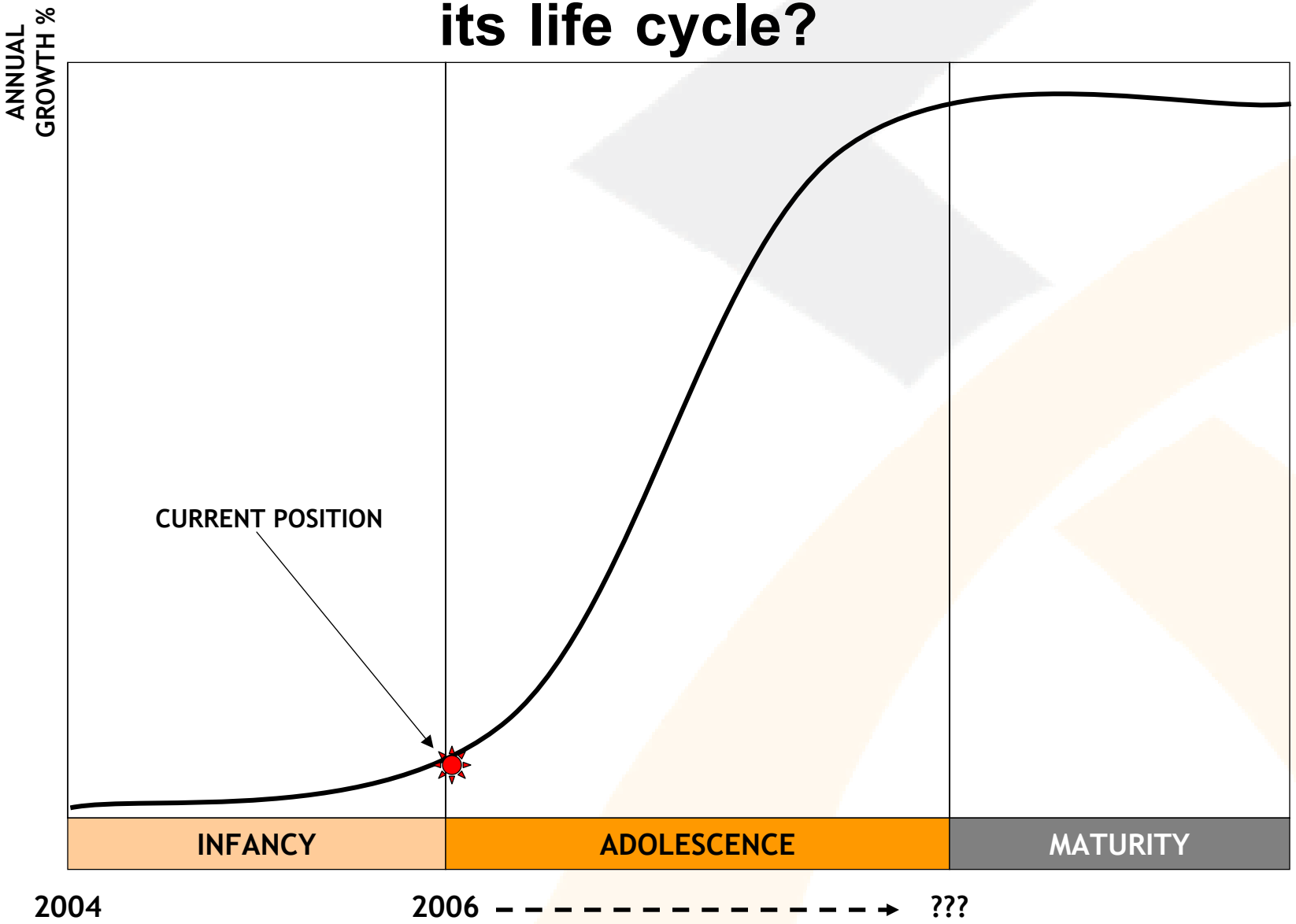
Types of Micro Health Insurance

Intermediary as:	
Insurer (CBHI)	• The largest number of International MHI experiments • Slow growth • In many countries they are ***'Illegal'*** • Substantial Innovation on product cover and process of delivery
Aggregator (Partner- agent)	• The fastest growing vertical • More stable • Theoretically, protects the client best • Possible in contexts where regulatory or market scenarios force/ encourage insurers to enter BOP markets
Govt. Subsidized schemes	• Fewer in numbers • Mostly marked by premium subsidies • Yeshaswini , Aarogya Sri • May be exposed to
Integrated (dual role of health provider+ insurer)	• Very few in example • May lead to adverse selection

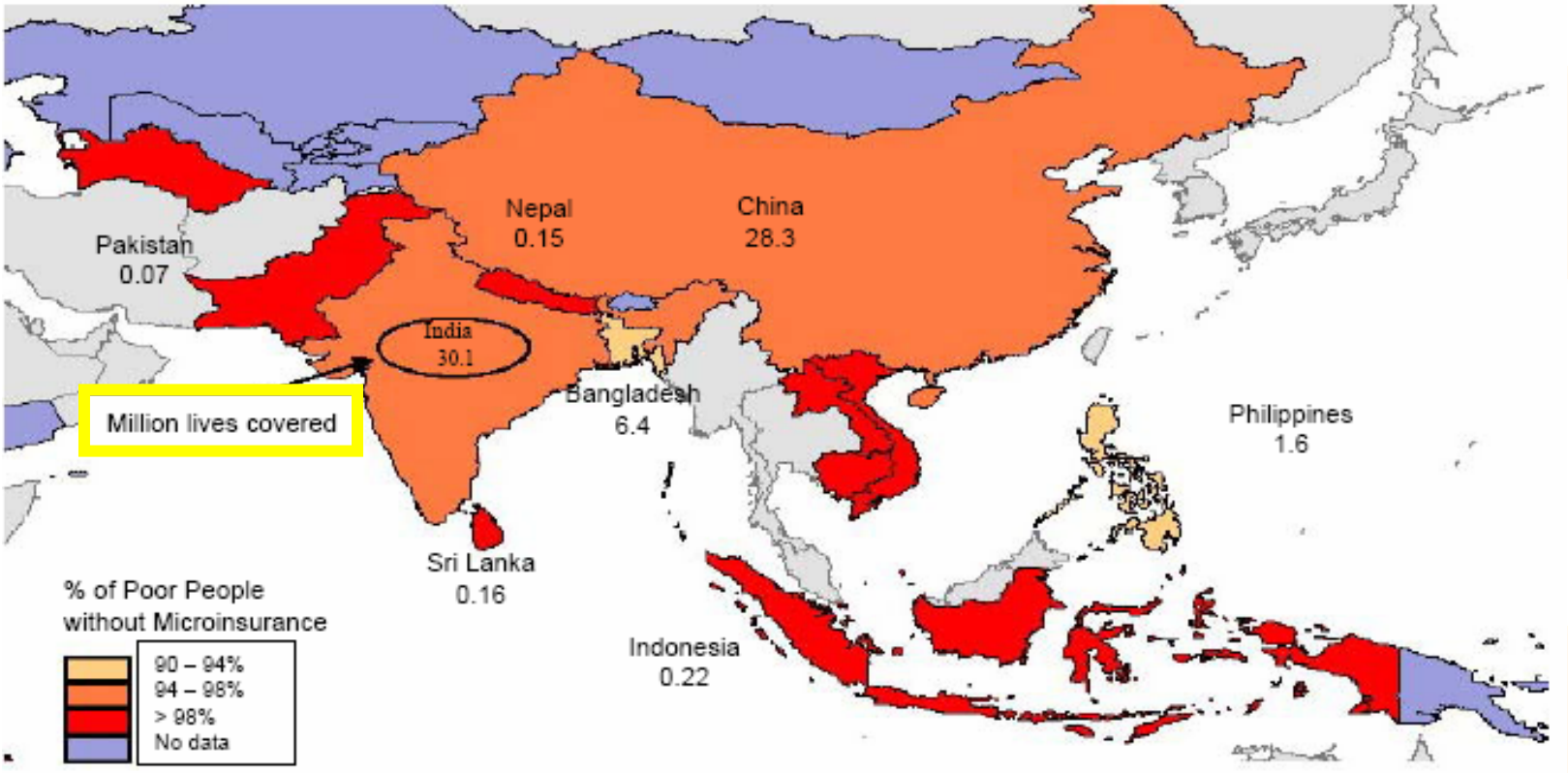
MHI models: poised to scale?

Alternate micro health insurance arrangements in India	Partner agent	CBHI	Govt. subsidized schemes
Nature of issues	(Sewa / Accord/Grameen Koota)	(VHS AND SEWAGRAM)	(Jan Arogya/ UHIs) Aarogya Sri
Transaction costs	Low- medium	Low	Medium
Membership Size	Not a issue	Important issue	Not an issue
Inpatient/ outpatient care. Could lead to cost escalation) and premium prohibitive	Is an issue	Not issue	Issue
Benefit On Provision Side	Negligible	Significant	Low
Risk reduction	Negligible	Significant	Negligible
Informational problems	Is an issue	Not issue	Issue
Maternity benefit	Is an issue	Not issue	Issue

Where is the micro insurance sector in its life cycle?



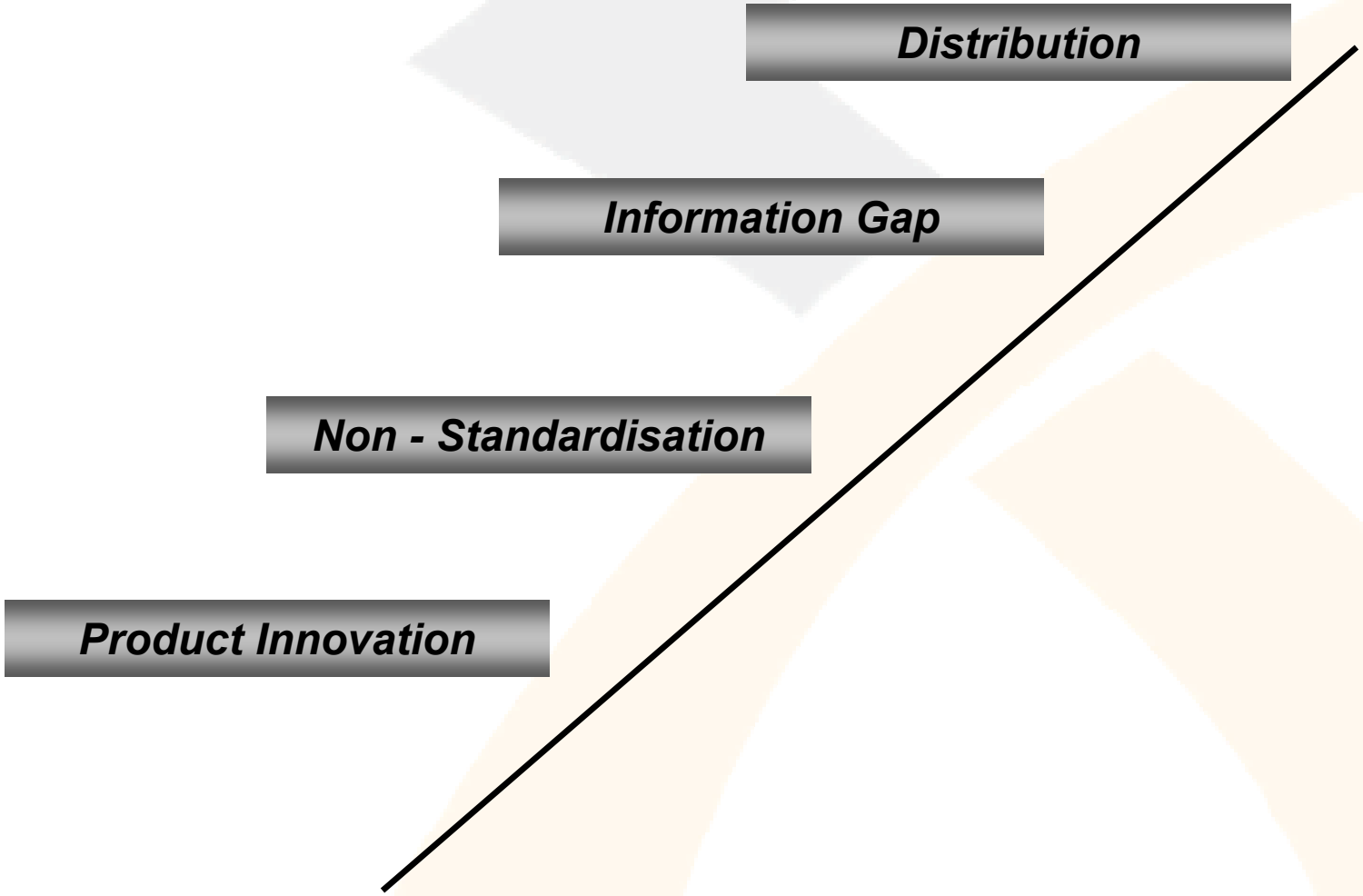
Micro Insurance: An Asian overview



500+ million people live in rural India

Source: Landscape of Microinsurance by Microinsurance Centre

Micro Insurance: Hurdles to Growth



Challenges to scale

- Information asymmetry
  - Product Design (Plan, Pricing & Coverage)
  - Moral hazard and adverse selection (Risk pool)
  - Cost containment
- Delivery channels (CBOs/NGOs/MFIs/ Kiosks)
  - Organizational skills and management
  - Insurance companies have limited outreach
- Provider network
  - Need for standardisation of medical costs
  - Need to control quality of health care

Duncan(1997) : Products to work need to address both supply and demand needs to be manages in this sector

Challenges and our Strategy

- Product Development:
  - Pricing: Predict the probability of claims
  - Challenges: prediction accuracy
    - **Precise determination of health risk difficult due to absence of observed morbidity and health data**
  - Presently community risk rating models are used, which may assume the risk of the whole community
    - This is not sustainable as more than representative number of unwell individuals tend to join the programme
  - Solution: to get *larger numbers* in *defined geographies* as operational cost, incentive to providers as bulk buyers and percentage of unwell clients in the pool are all affected positively through an **"Area Saturation Approach"**
  - Present pilots mostly are based on 'competitor reaction' or 'make do' inadequate information

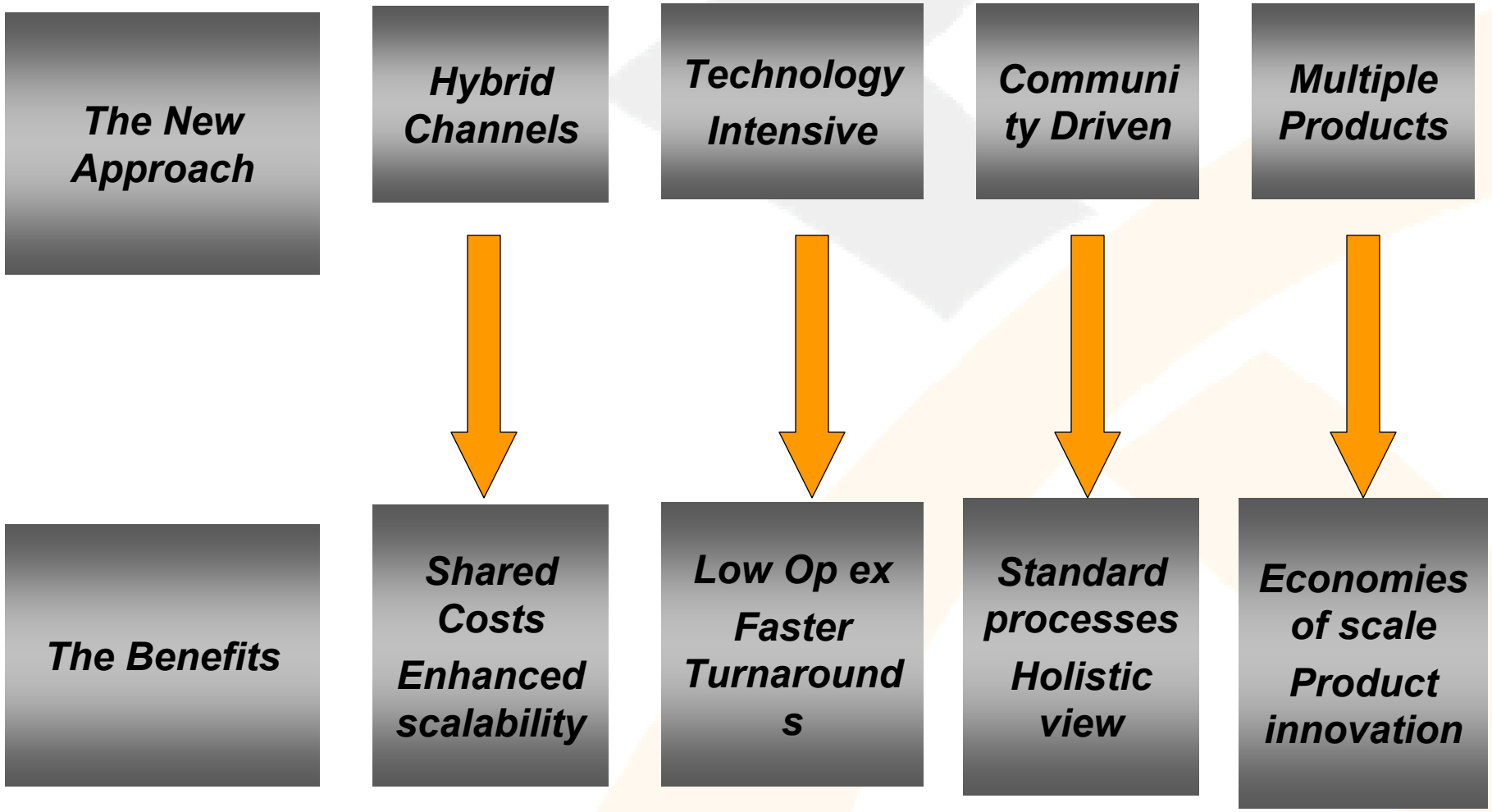
Challenges and our Strategy

- **Options:**
  - **Burn your fingers to create data**
- **Will help to profile differentiation for better risk assessment**
- ***What we do:***
  - In each of our pilots we are trying to create an ‘Electronic Health record’ of the client, and believe while it is an investment in facilitative infrastructure and will help in discovery and better informed, more scientific products
  - Such investment can also be used for delivery of other services, and cheaper credit programmes for MFIs
  - Data formation cost: some health incidents may require negligible investment and require only accessing existing data. This should used immediately, subsequent programmes can justify more costly data creation investments

Challenges and our strategy

- **Product delivery/ Transaction cost**
  - Use partners/ aggregators, intermediaries
  - Segregate interaction of community with provider
  - Entrepreneur models where incentives are based on MHI covers could bring bad risk and make MHI unsustainable and lead to higher community risk assessment
    - ***What we do:***
      - **Do without initial physical check up**
      - **Exception where partner has existing pre check infrastructure,**
      - **Most interaction with community to be limited to 'NGO staff'**
      - **Information and cash channels clearly defined and require maximum efficiency *(high degree of customisation to existing systems is not a good idea, initial investment to upgrade systems is a better idea than face per transaction challenge)***
      - ***Cash: Payment channels to be invested and justified if multiple service, like micro credit, pesticides, govt. social security programmes use these paymanet channels and allow sustainability***

Our strategy



An emergent Model: The Health Ecosystem Pilot

- A public private community partnership model
- Providing cashless complete health care in a defined geography
- Addressing access barriers like Transportation , Drugs and Diagnostics
- Developing a comprehensive health database with individual ‘Electronic Health record’
- Controlling fraud through Health cards and strong MIS systems
- Data Updation through a strong back end system

An Emergent Model: The Health Eco-system Model

- Patient referred to the secondary level from govt. primary care facility
- The pre-authorisation by the joint collaboration of Medical Officer of PHC and CBOs.
- Defined protocol for diagnostics and treatment procedures to be maintained *(to avoid supply side moral hazard)*
- Generic Drugs by pharmaceutical partner (*to control costs)*

An emergent model: The Health Ecosystem Pilot

- **Based on seriousness, referred to tertiary level.**
- **Decisions to keep a patient at secondary or tertiary level needs to be taken at secondary level to cut costs.**
- Overall preventive and promotive activities to be carried out by workers of the CBOs/MFIs.

An emergent Model: The Health ecosystem model

- Clients are provided with smart card.
- It can store:
- Identification details.
- Insurance details.
- Health details.
- All these information can be uploaded in a central “data warehouse” which will work as a basic health exchange for the sector.

Current partnerships…

- Pharmaceutical partners:
  1. **Pfizer**
  2. **Novartis**
- Community organisations:
  1. **BYRRAJU Foundation. (A.P)**
  2. **Sarva Swasthya Mission. (Jharkhand)**
  3. **Dharmasthala trust. (Karnataka)**
  4. **Aga Khan Health Services. (Gujarat)**
  5. **Manipal healthcare.**
- Insurer partners:
  1. **ICICI Lombard. (for general health insurance)**
  2. **ICICI Prudential. (for life+critical illness).**

Unified Delivery Process

ENROLL

- Standardised minimum KYC for rural customers
- KYC extended for all products
- Fingerprint captured for unique identity

IDENTIFY

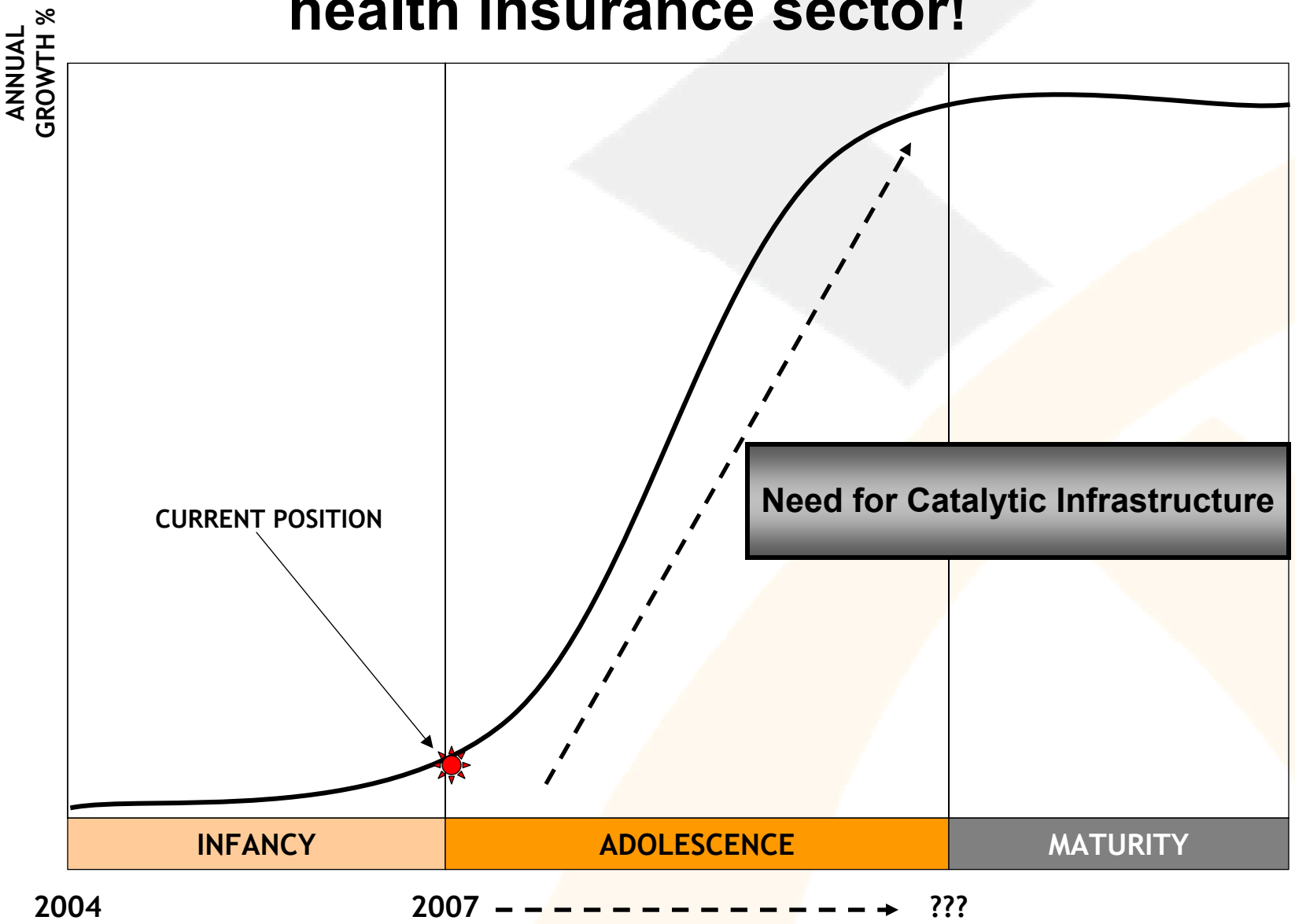
- Customer issued a Smart Card with Fingerprint
- Unique ID at customer level
- Unique ID persists across products for single customer view

TRANSACT

- Transaction authenticated with Card and Fingerprint
- Terminal-based transactions
- Terminals carried by Agents
- Same mechanism irrespective of end product

CIRM: The Mandate

To jumpstart the growth of the micro health insurance sector!



Facilitative Environment for Micro Insurance

Smart Subsidy:

- **Technology and MIS for the sector for creation of identity, health history and DATA**
- **Standardization**
  - **Of health and medical procedures, especially for communities with very low health knowledge**
  - **Lack of adequate standards on documentation across processes and providers (health and insurance)**
- **Sensitization of stakeholders** like
  - **Govt. Departments (Min. of Fin, Min of Health)**
  - **Service Providers(diagnostic, drug, nursing homes and tertiary care hospitals)**
  - **Insurers and aggregators.**
- **Incentive to Sell**
  - Transaction costs for delivery of micro-insurance need to be adequately recovered. General commission structures applicable to the commercial sector may not perfectly meet micro-insurance requirement
  - Insurance competes with high payoff products such as loans, mutual funds, etc on the agent's priority list

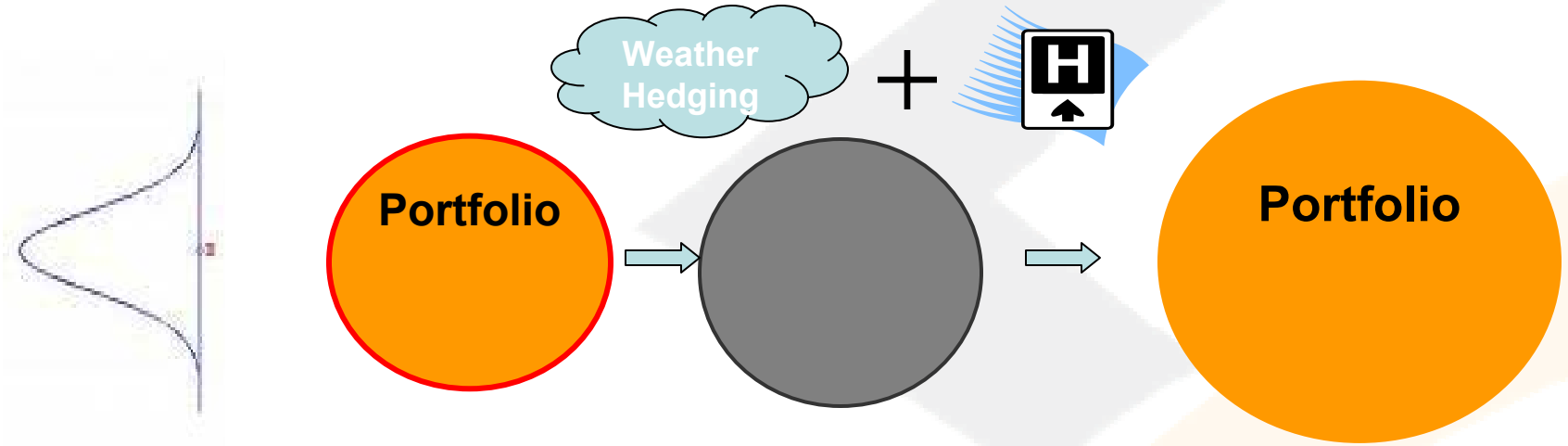
For the jump start…

- **Product Pilots**
- **Reinsurance**
- **Data, Data, and more Data!!**
  - Health Exchange,
  - Morbidity data sets
- **Insurance Census (eg. Fin MARK T**
- **Training and Education**
  - Building trained professionals for t
  - Insurance Literacy material for
    - Insurers
    - Intermediaries (CBOs, Co-ops, MFIs)
    - Beneficiaries

Enabling Infrastructure to get safety nets for all

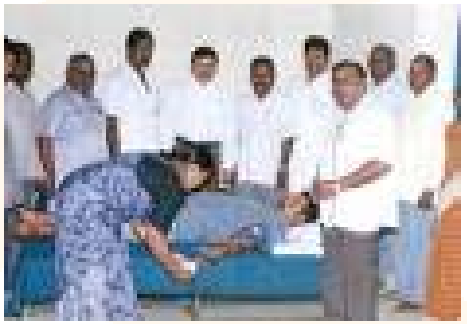
Thank You

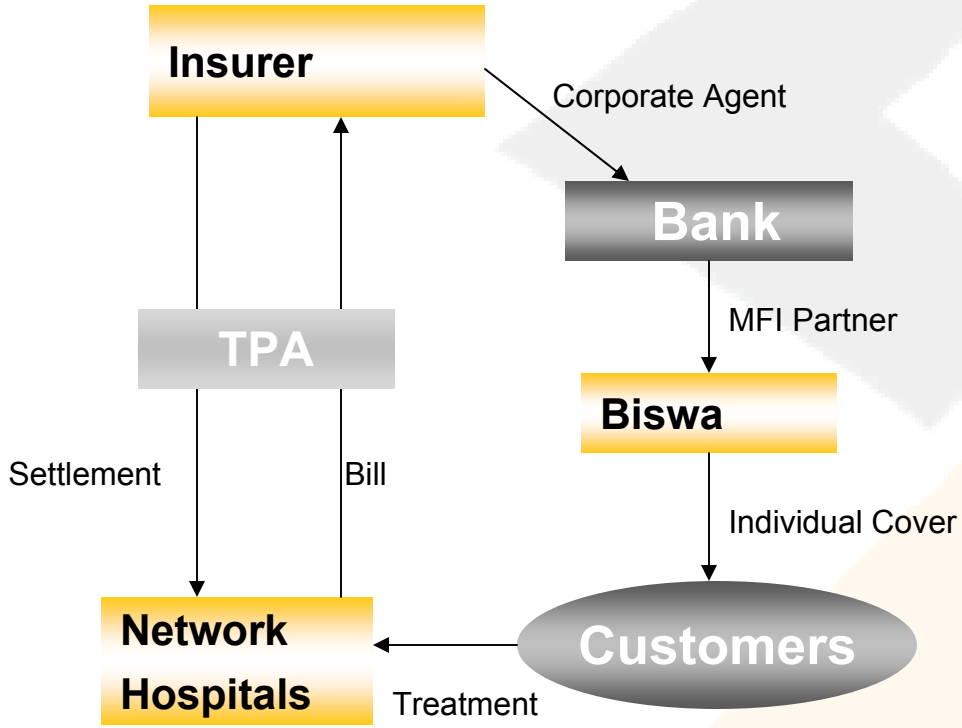
Innovative Products: De-risking Rural Credit



- **Ring fencing** of rural portfolio of banking and financial institutions that has a health and weather risk component
- Effective risk hedging through health insurance and weather derivatives will free up blocked capital
- Increased risk appetite coupled with health and weather derivatives will allow aggressive growth in rural portfolio extending credit to the vulnerable populations

Innovative Delivery channels: Biswa

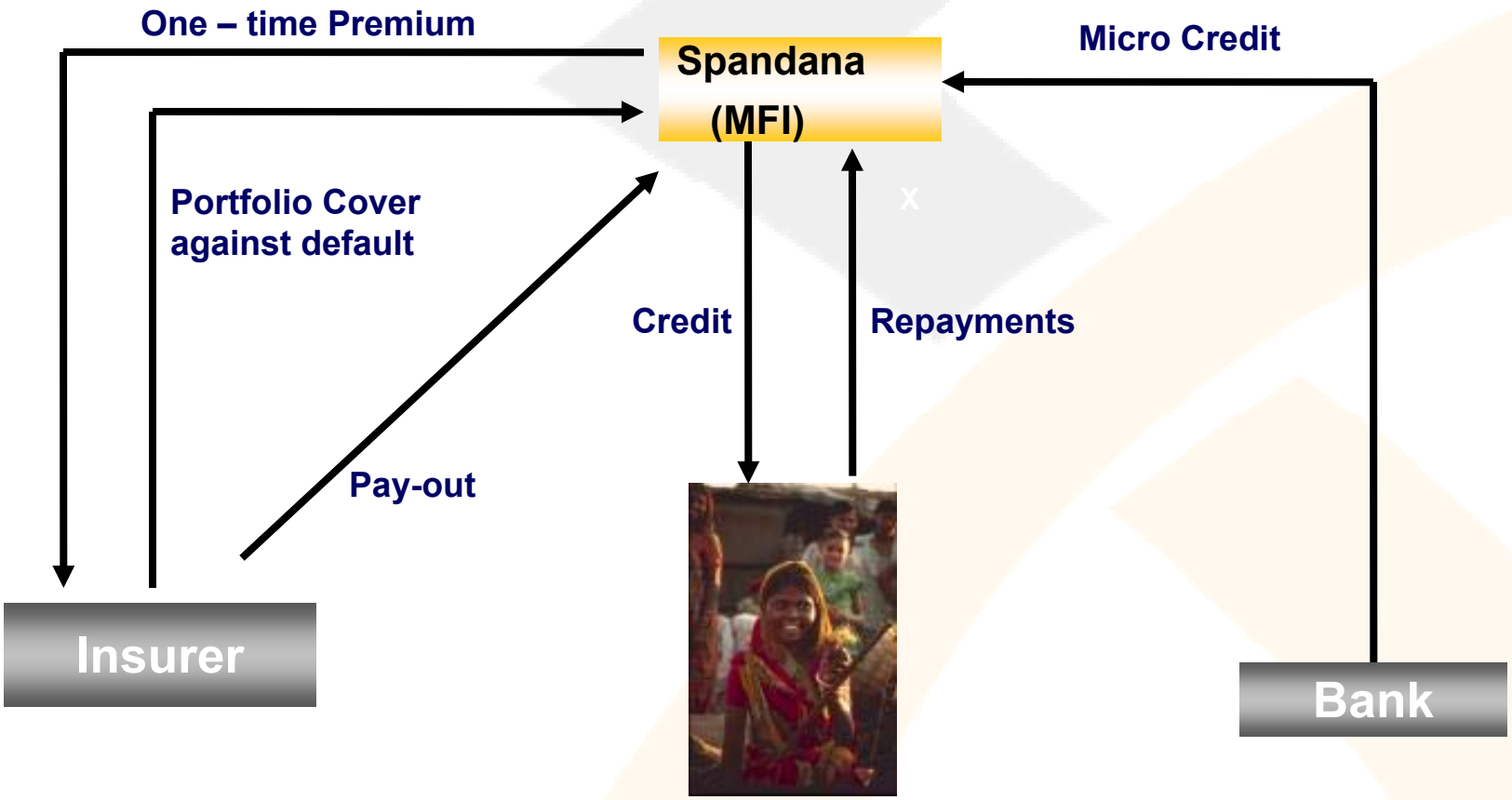




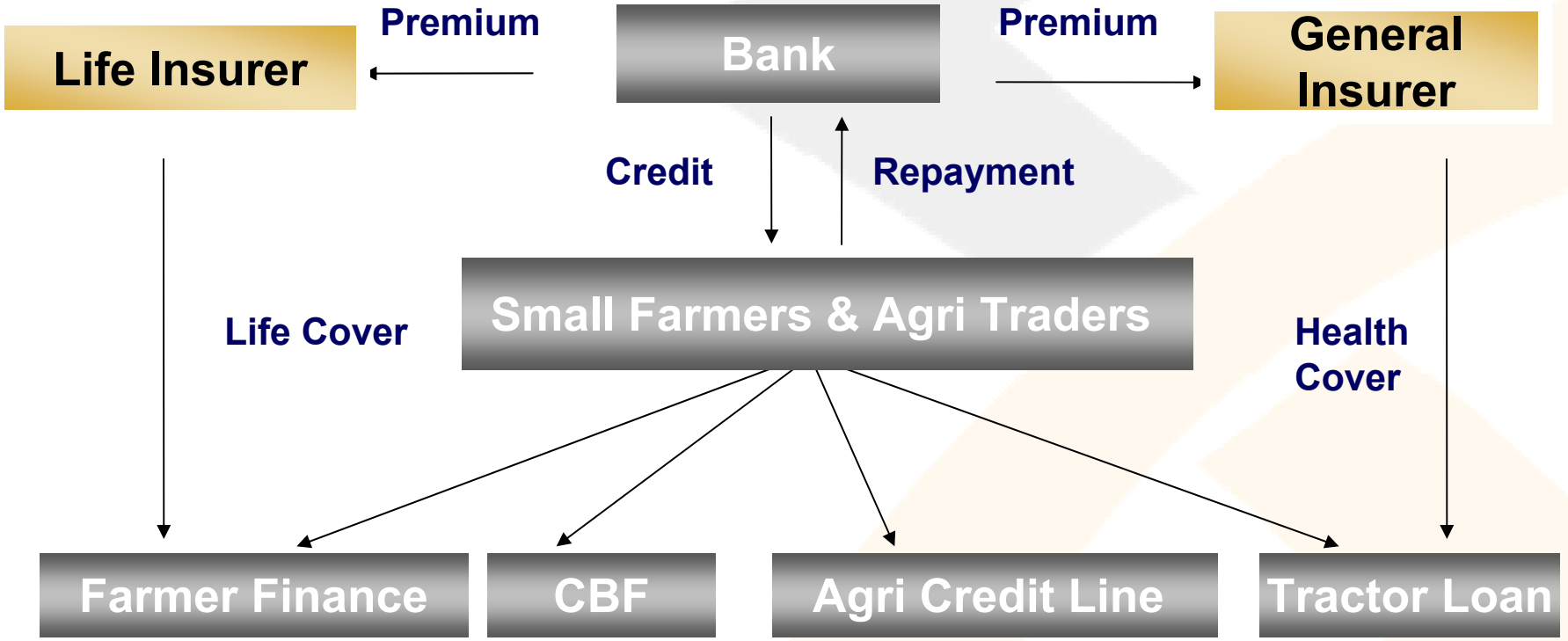
Cover: Cashless Hospitalization & Personal accident cover

Health cover to 500,000 lives in the state of Orissa (2006-07)

Innovative Delivery channels: Derisking Credit Portfolio: Spandana



Delivery channels: Bundling Insurance with Credit Channels



CBF – Commodity Based Finance

Issues in Health financing and its effects

Public Sector Health Personnel in Rural Areas	
Profession	**Numbers**
Doctors	29,000
Nurse Midwives	18,000
Auxilarry Nurse Midwives	1,34,000
Male multipurpose workers	73,000
Pharmacists	21,000
Para Medical Staff	60,000
Source: Ministry of Health & Family Welfare, 2000	

Issues in Health financing and its effects

Type of Patients	Year			
	86-87		96-97	
	Rural	Urban	Rural	Urban
Percentage Population Treated as Outpatients				
Public	26	28	19	20
Private	74	72	81	80
Percentage Population Treated as In-Patients				
Public	60	60	44	43
Private	40	40	56	57

Source: World Bank, 2001

Issues of Health Financing in Africa

- Has largest number of countries per square kilometer area of developing region
- Every country on an average has four neighbors
- Sub-Saharan Africa are heterogeneous countries with GDP per capita 200-7000 USD (India has a GDP per capita at 920USD)
- 1/3rd of worlds resource dependant countries are here
- 45 small economies and 2 regional powers (SA and Nigeria)
- SA and Nigeria together account for 55% of the continents economic activity
- 18 countries, accounting for 36% for Africa's population have grown in a sustained manner over the decade
- 14 countries have experienced little or negative GDP per capita growth and may have been affected by Conflict(Burundi, Eritrea, Demo. Republic of Congo