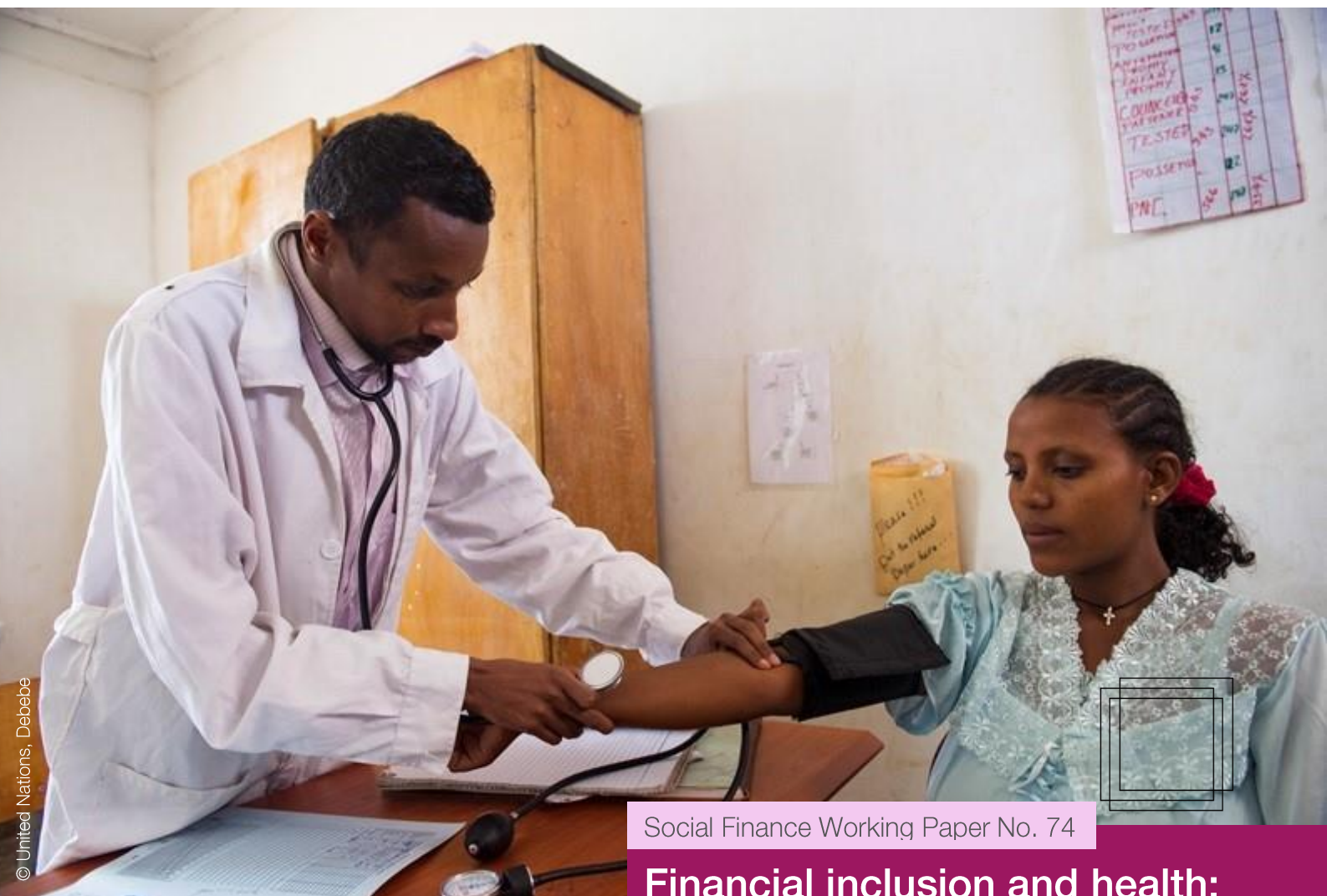




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Financial inclusion and health: How the financial services industry is responding to health risks

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Lisa Morgan and Craig Churchill
International Labour Organization

May 2018

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ACRONYMS AND ABBREVIATIONS

ARPU	Average revenue per user
FSP	Financial Service Provider
ILO	International Labour Organisation
MFI	Microfinance institution
MNO	Mobile network operator
MSEs	Micro and small enterprises
NGO	Non-governmental organisation
PPP	Purchasing power parity
PPPs	Public-private partnerships
SDGs	Sustainable development goals
OECD	Organisation for Economic Co-operation and Development
OOP	Out-of-pocket expenditure
UHC	Universal health coverage
WHO	World Health Organisation

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EXECUTIVE SUMMARY

For development experts working on financial inclusion, ensuring that low-income households have bank accounts and can access loans is not a sufficient objective. Financial inclusion – the provision of affordable financial services to low-income segments of society – is really a means to an end. Access to financial services by itself does not contribute to development, but rather it depends on how those financial instruments are used.

Ill health is both a result of and cause of poverty – attaining good health is therefore an intrinsic objective that cannot be ignored in the pursuit of social and economic empowerment. The World Health Organization estimates that each year about 150 million people around the world suffer financial catastrophe from out-of-pocket expenditure on health services, while 100 million are pushed below the poverty line. Unless health issues are addressed, the impact promised by access to finance will be limited.

Developing health solutions can be a triple win for clients, society and financial service providers (FSPs). For FSPs, the main intended audience of this paper, keeping clients and their families healthy makes business sense. While there is great demand for such solutions, only a few FSPs have focussed on tackling health challenges. There is considerable scope for further experimentation.

This paper begins by exploring the context of health, highlighting the different costs associated with maintaining good health, and the efforts of governments to support citizens in managing these expenses. These health costs include non-medical expenses often omitted from the discussion on health expenditure, such as the lost income while ill. Different financial instruments, such as savings, credit and insurance, as well as non-financial services are then discussed, illustrating how they can contribute to managing health expenses. The paper also draws on a number of case studies where FSPs have developed products and services to specifically tackle health needs. From these case studies, a number of key themes have emerged:

1. **FSPs have the potential to be powerful distribution agents, helping enrol those in the informal sector into government health schemes.** For example, M-TIBA in Kenya, a mobile ‘health wallet’ on a digital platform, connects patients, healthcare providers and healthcare payers. M-TIBA is acting as an agent to enrol low-income households into the National Hospital Insurance Fund (NHIF) (see Case Study 4).
2. **Health savings and credit products are possible solutions for smaller health expenses, with savings having a potentially greater protective impact over the long term.** Research shows that when households have access to health savings accounts, it is possible that their long-term health costs will be lower because healthcare can be sought earlier (see Case Study 1).
3. **Insurance can play a complementary role, helping to cover lost income and out-of-pocket (OOP) expenses.** FSPs should not try to compete with or substitute government-sponsored comprehensive health cover – generally any FSP would struggle to attain the required degree of risk pooling that a government can, and this is needed for the cross-subsidies from the wealthy to poor and healthy to sick that make a comprehensive healthcare package affordable to the poor. Unlike insurance companies, Universal Health Coverage (UHC) schemes have the potential to raise additional revenues through taxation. However, even where UHC schemes exist, citizens are still expected to cover OOP and non-medical expenses, such as medication, lost income while sick, transportation to the hospital and home, meals and other such associated expenses. An ill-health episode can generate a string of such expenses. These coverage gaps represent a possible opportunity for FSPs if they can design financial solutions to manage the risk of these residual expenses. These solutions can be critical because, for low-income populations, even

small OOP expenses can be barriers to accessing healthcare.

4. **Besides financial services adapted for health, FSPs can also consider bundling non-financial solutions, also known as value-added health services, with savings, loans and insurance.** Value-added services include reward-based schemes to incentivise healthy behaviour (see Case Study 15), telemedicine, health tips, provider checks, negotiated discounts (see Case Study 14) and the direct investment into the health of clients (see Case Study 13).
5. **For maximum impact, FSPs can bundle together a number of different health-focussed products and services.** Packages that combine access to government health schemes with health savings accounts, health loans, supplementary health insurance, and relevant value-added services could make an important contribution to combatting the cycle of poverty by helping households and micro and small enterprises (MSEs) manage their health risks.
6. **Gender dimensions need careful considerations when designing products and solutions.** The relationship between women, family health and barriers to financial inclusion need to be carefully understood before products and solutions are designed (see Case Study 1).
7. **Pilots are important.** Addressing financial needs related to health can be complex and products may need a number of iterations before they succeed. Careful planning and piloting was one of the reasons for success cited by Jordan's Microfund for Women for its health insurance product "Caregiver" (see Case Study 7).

Evidence shows that FSPs can have a significant impact on the health of their clients and their families. Developing new solutions starts with a thorough understanding of the country context and understanding the needs and lives of clients. There is great scope for FSPs to develop new health solutions, especially with advances in mobile and health technology. Given that FSPs working on financial inclusion already have an understanding of and access to populations typically excluded from health cover, the financial services industry is well placed to expand its repertoire, reap the rewards of healthier customers and contribute to better global health.

1. Introduction

BOX 1. Poverty and Health – Monicah and Isaac’s Story

The health plight of low-income households is well illustrated by the story of Isaac and Monicah, participants in the Kenya Financial Diaries study. Shortly after delivering her third baby, Monicah fell ill. It was not long before the couple had exhausted all their funds on medicine and inconclusive diagnostics. Eventually Monicah was diagnosed with a throat tumour that required surgery. Isaac and Monicah were unable to raise the KSh 23,000 (USD 227) needed to pay for the surgery, and Monicah died.

Ironically, funds from friends and family worth more than that – KSh 33,000 (USD 326) – then flooded in to help pay for funeral expenses. Things for Isaac deteriorated; he too developed health problems, was forced to rehouse his children with relatives and eventually became homeless.

This is unfortunately a typical scenario facing many people in the world, where inadequate access to affordable quality care drives families into poverty. The United Nation’s Sustainable Development Goal (SDG) 3 strives to ensure happier endings with the ultimate goal being universal health coverage. To achieve this goal, financial inclusion can and should play a critical role in boosting a nation’s health and well-being. In fact, financial inclusion has been identified by the World Bank as an enabler for 7 of the 17 SDGs. This paper explores how the financial services industry is responding to the health risks impacting low-income households and micro and small enterprises.

Adapted from: Kenya Financial Diaries, Shilingi Kwa Shilingi - the financial lives of the poor, 2014.

For development experts working on financial inclusion, ensuring that low-income households have bank accounts and can access loans is not a sufficient objective. Financial inclusion – the provision of affordable financial services to low-income segments of society – is really a means to an end. Access to financial services by itself does not contribute to development, but rather it depends on how those financial instruments are used.

The initial development agenda for financial inclusion, or microcredit as it was then known, was to assist micro and small enterprises (MSEs), or the entrepreneurs running them, to create jobs and increase incomes. More recently, there have been efforts to encourage the use of financial inclusion for a range of different objectives such as promoting solar power, enhancing food security, or creating youth employment.

One area that warrants greater attention is the contribution of financial inclusion to health. This area could involve a variety of interventions, ranging from an HIV/AIDS or maternal health awareness campaign to specialized health savings accounts and emergency loans for health expenses to health insurance products. Developing these health solutions can be a triple win for clients, society and financial service providers (FSPs).

For low-income households to avert poverty, they need family members who are healthy enough, for long enough, to be sufficiently economically active to accumulate wealth and thus become financially resilient. If breadwinners run or work in MSEs, those enterprises need a healthy workforce to profit, remain sustainable and grow. As illustrated by Monicah and Isaac’s story (see Box 1) and Figure 1, ill health can be financially catastrophic, eroding savings, depleting working capital, causing loan defaults and exacerbating indebtedness. Health related financial risks are frequently cited as a root cause of impoverishment for low-income families. The WHO estimates that about 150 million people around the world suffer financial catastrophe from out-of-pocket expenditure (OOP) on health services, while 100

million people are pushed below the poverty line annually (Kieny 2016). Unless health issues are addressed, the impact promised by access to finance will be limited.

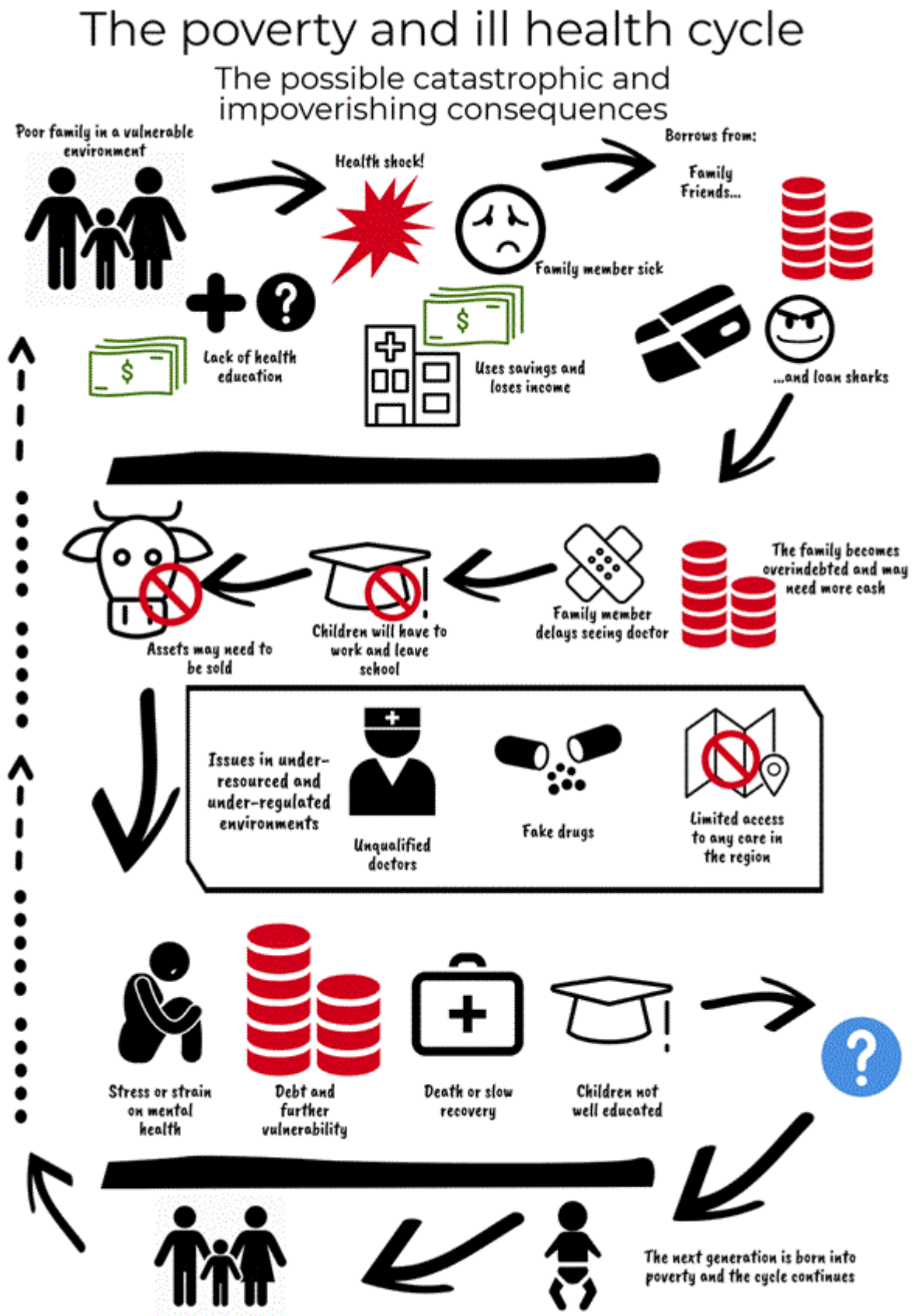
From a societal and economic perspective, improved health outcomes drive economic growth, employment and social development. As stated by the WHO, “good health allows children to learn and adults to earn, helps people escape from poverty, and provides the basis for long-term economic development” (WHO Media Centre 2017).

From the view point of FSPs - including banks, credit unions and microfinance institutions (MFIs) - keeping clients healthy makes business sense. While some may approach this issue to support their corporate social responsibility agenda or to achieve a social mission, many interventions can contribute to their financial bottom line. If households encounter a health shock, they may struggle to pay for the treatment, or meet their other financial commitments, such as repaying loans. Healthy and economically active clients are more likely to earn and save more, and repay their loans. In addition, they may have greater financial resources to purchase other services. Therefore, providing services to help clients to effectively manage their health needs has the added benefit of protecting the FSP’s loan portfolio.

A few FSPs have been working on health issues, some for many years. This paper draws on their insights, collected through interviews and a literature review, to synthesize the experiences to date. It is hoped that the contents will shed light on how FSPs can better serve clients with tools to help them manage their health-related financial risks and also motivate more FSPs to specifically target health challenges.

This paper begins by exploring the context of health, highlighting the costs associated with maintaining good health, and the efforts of governments to support citizens to manage these expenses. Subsequent sections review the range of financial and non-financial services offered by FSPs to assist their clients to manage health risks more effectively. These include savings and credit products, a variety of insurance solutions, illness prevention and wellness promotion, and even the provision of healthcare itself. The paper ends with a section highlighting some of the key ways FSPs can coordinate with government health programmes.

Figure 1. The poverty and ill health cycle



Source: the ILO's Impact Insurance Facility, 2018.

2. Different types of health expenses

When one thinks about how financial services can support improved health outcomes, it is necessary to disaggregate the expenses into their component parts. The purpose of this grouping is to familiarise the reader with the broad categories of healthcare expenditure and to start the discussion about which financial services might be appropriate to manage different sets of costs. There are five main categories of healthcare expenses to consider, although within some of the classifications there are several subsets.

1. Primary and outpatient care

Also known as ambulatory care, one accesses outpatient (OP) healthcare services from a clinic or a primary care provider. Typically these services can be split into two types of care, preventative and curative. The former includes check-ups (e.g. dental and optical), vaccinations and screenings, while the latter is the treatment of illnesses and diseases that do not require hospitalization. When performed in an outpatient setting, outpatient care includes diagnosis, observation, consultation, treatment, intervention, and rehabilitation services.

2. Inpatient care

Inpatient (IP) services are when the patient is required to stay at the healthcare facility overnight or longer. This care could fall into three general categories: a) elective surgeries and planned events like maternity; b) treatments for accidents and emergencies; and c) acute or chronic illnesses. In addition to the expenses for the healthcare itself, there are also additional costs for IP accommodation, food, medical tests and supplies. Any medical services provided whilst admitted as an inpatient are considered as IP services, and are typically more expensive than similar services provided in an OP setting. As medical technology improves, it is becoming possible to shift certain procedures from IP to OP, which can bring down costs.

3. Care for non-curable conditions, and care for the elderly

Long term care for chronic diseases and disability: Chronic diseases are illnesses that generally cannot be prevented by vaccines or cured by medication. Long-term care includes a variety of services which help meet both the medical and non-medical needs of people with a chronic disease or disability who are unable to care for themselves for long periods. Long-term care often involves recurring expenses. Chronic diseases and disabilities may compromise the ability to work full time or prevent patients from working, thus having long-term medical and financial implications.

Elderly care: Elderly care is the fulfilment of the special needs and requirements that are unique to senior citizens. This broad term encompasses such services as assisted living, adult day care, long-term care, nursing homes (often referred to as residential care), hospice care, and home care.

Palliative care: Palliative care is a multidisciplinary approach to specialized medical and nursing care for people with life-limiting illnesses. It focuses on providing people with relief from the symptoms, pain, physical stress, and mental stress of a terminal diagnosis.

4. Wellness

Wellness is a broad category of health promotion and illness prevention, primarily through awareness raising and information sharing. As Benjamin Franklin astutely noted, an ounce of prevention is worth a pound of cure.

5. Associated costs

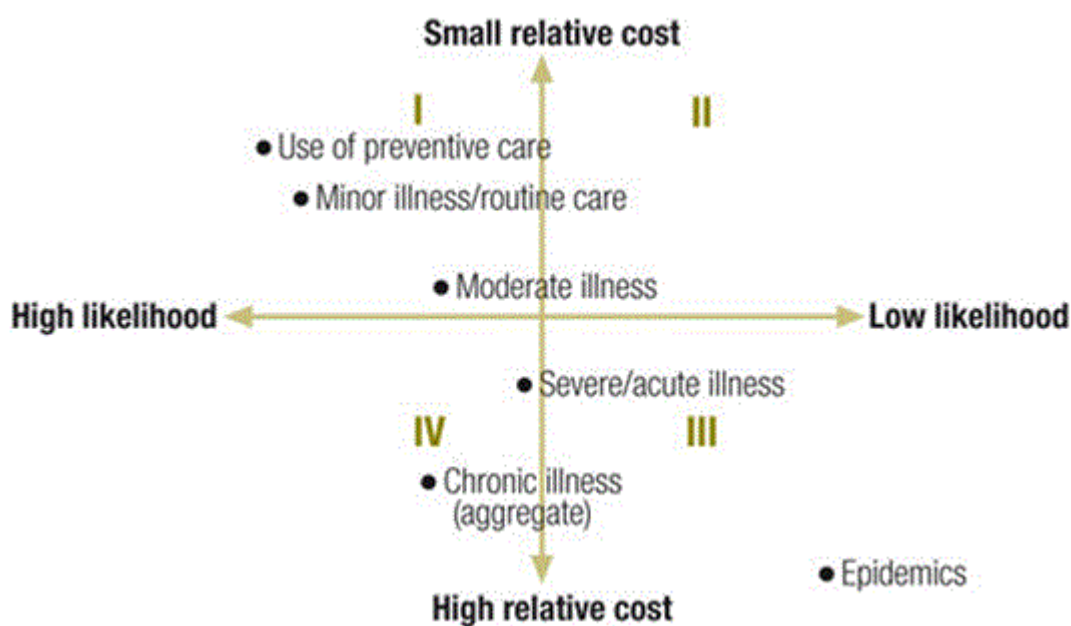
This category is a catch-all that includes the cost of everything else not captured in the above four categories, such as:

- Pharmaceuticals;
- Parent or family accommodation in the hospital (where there is a charge);
- Durable medical equipment (e.g. wheelchairs) and prosthetics;
- Transportation to medical facilities (via ambulance or otherwise);
- Loss of income when one is unable to work; and
- Co-payments and any other OOP costs.

2.1. HEALTHCARE COSTS CATEGORISED BY FREQUENCY AND SEVERITY

In any healthcare financing model the two key statistics needed are the frequency and average cost (severity) of different categories of healthcare services. When thinking about financial risk management from an individual's point of view, it is also useful to think about healthcare costs by these two broad dimensions. As illustrated in Figure 2, some health expenses occur frequently (high likelihood) and others infrequently (low likelihood); some are quite high cost and others less so. Not depicted in this figure are the associated or non-medical expenses, but from the perspective of a low-income person, these can be quite substantial and important to consider.

Figure 2. Cost and likelihood of health expenses



Source: *Bulletin of World Health Organization*, 2010.

2.2. WHAT IS UNIVERSAL HEALTH COVERAGE?

Fortunately, FSPs are not alone in thinking about the health risks of their clients. An increasing number of governments are expanding health cover, with many aspiring to achieve Universal Health Coverage (UHC), as articulated in the Sustainable Development Goal 3 (SDG) on Health and Wellness.

To investigate the role FSPs can play, it is useful to first clarify what UHC is and what it is not (see Box 2); by keeping this in mind, appropriate supplementary solutions can be developed that do not undermine or reduce the willingness of countries to invest in their UHC programmes. UHC does not mean free healthcare for everyone for every medical condition, but it does mean that they should receive essential services without experiencing financial adversity.

BOX 2. Universal Health Coverage as defined by the WHO

What is UHC?

UHC means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.

UHC enables everyone to access the services that address the most important causes of disease and death, and ensures that the quality of those services is good enough to improve the health of the people who receive them.

Protecting people from the financial consequences of paying for health services out of their own pockets reduces the risk that people will be pushed into poverty because unexpected illness requires them to use up their life savings, sell assets, or borrow – destroying their futures and often those of their children.

What UHC is not

There are many things that are not included in the scope of UHC:

UHC does not mean free coverage for all possible health interventions, regardless of the cost, as no country can provide all services free of charge on a sustainable basis.

UHC is not just about health financing. It encompasses all components of the health system.

UHC is not only about ensuring a minimum package of health services, but also about ensuring a progressive expansion of coverage of health services and financial protection as more resources become available.

UHC is not only about individual treatment services, but also includes population-based services such as public health campaigns, adding fluoride to water, controlling mosquito breeding grounds, and so on.

UHC is comprised of much more than just health; taking steps towards UHC means steps towards equity, development priorities, and social inclusion and cohesion.

Source: WHO website <http://www.who.int/mediacentre/factsheets/fs395/en/> as at January 2018.

3. Integrating financial inclusion and health

Over the last decade a few FSPs have taken up the challenge of developing financial health solutions for low-income clients and MSEs, however there is significant scope for further innovation. A study by Leatherman et al. (2011) identified 89 organisations that provided both microfinance and health interventions. The most common health intervention offered was group-based health education sessions (offered by 80 percent of the organisations studied). According to the study, health education can have a significant impact. Only 2 percent offered health savings accounts while 6 percent offered tailored health loans. Just under 20 percent of the organizations offered microinsurance, which in this particular study was defined as either being private microinsurance or access to government health cover.

While non-financial health interventions (such as health education) are generally appreciated by clients and do have impact, there is greater demand for health-related financial risk management solutions. In many countries, the demand far exceeds the available supply. Research done by the ILO shows that the demand for any form of health cover by low-income households is frequently higher than for any other type of financial risk management solution (Matul et al., 2013).

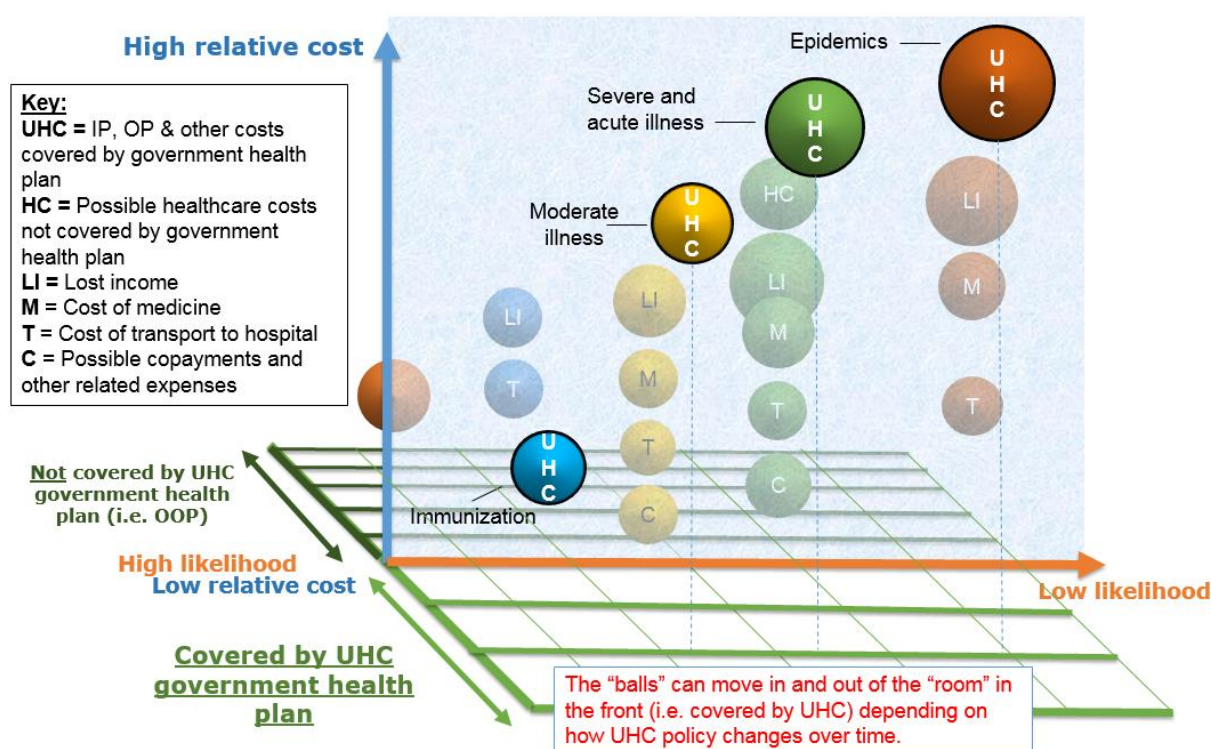
When designing possible financial solutions for health risks, it is useful to start by identifying the frequency (or likelihood) and the severity (high or low cost), as mentioned above. There is, however, a third dimension to consider, namely whether UHC reform is underway, whether a government health plan exists and which expenses and services it covers. With these variables, it is possible to consider how different financial services would be most relevant for different health risks:

- **Smaller and high frequency (i.e. expected) health expenses:** Relatively smaller expenses, especially expected expenses, not covered by UHC health schemes, could be covered by savings where possible, with emergency loans filling the gap. Understanding the timings of recurrent expenses (e.g. for check-ups and known illnesses) would help low-income households anticipate and save. Who is included? It is also important to stipulate upfront whose medical expenses should be included in the health savings account. Ideally, it should include anyone that the depositor will have an obligation to pay for, but that could be a long list.
- **Higher cost and lower frequency health expenses:** In general, higher cost and lower frequency events are better suited to risk pooling solutions. For high-cost health expenses, government-sponsored health schemes would be the most appropriate financing mechanism. FSPs should not try to compete with or substitute government-sponsored health cover as they would not be able to attain the required degree of risk pooling that a government can, which is needed to make healthcare affordable to the poor. Simply put, healthcare is expensive, and for the insurance mechanism to work you need to pool wealthy and healthy people with the poor and unhealthy – not something easily achieved outside of UHC schemes, which also have the potential to raise additional revenues through taxation. Ideally, solutions developed by FSPs should complement government health schemes, avoid duplication and make the best use of combined resources.
- **Smaller and low frequency (i.e. less predictable) health expenses:** Less catastrophic or non-medical OOP expenses could also be managed by savings, credit or insurance, such as a hospital cash product that pays a per diem amount for each day one is in the hospital. UHC schemes cannot cover all costs associated with ill health, nor does UHC promise this. The degree of coverage provided by each UHC scheme will differ depending on a country's fiscal space for health. Over and above what UHC schemes can cover, if they exist, citizens are still expected to cover some out-of-pocket and associated expenses, and these may not

always be predictable. Furthermore, UHC schemes do not promise to cover lost income while sick, transportation to the hospital and home, meals and other such associated expenses. All of these coverage gaps represent an opportunity for FSPs, which can design financial solutions to manage these residual expenses. These solutions can be critical because, for low-income populations, even small OOP expenses can become barriers to access healthcare.

Figure 3 captures the above discussion and should be imagined as two “rooms” – front and back room divided by the light blue screen. The balls floating in the front and back room represent expenses. The larger balls represent relatively larger expenses, and the colour coding indicates that they are related to the same episode of ill-health. Each time an ill health event occurs, a string of expenses is generated, some of which can be borne by the government health plan in place (assuming that the person is covered), while other OOP expenses are left to the individual to cover. Anything which falls into the front room represents health expenditure typically covered by government health plans. Balls in the back room are not; it is for these expenses that health-related financial services can be designed.

Figure 3. Health expenses by cost likelihood and UHC government health plan coverage



Source: the ILO’s Impact Insurance Facility, 2018.

Little is available on how FSPs can help with the long-term care needs of clients, as this is usually not the most imminent priority. While micro pensions in the form of savings are being piloted in some countries and could be an appropriate solution to help finance long-term care (Khanna et al.2017), more research and experimentation is needed for the best way to manage these expenses. The problems associated to financing long-term care for ageing populations globally are yet to be solved.

4. Financial and non-financial health solutions for low-income clients

Section 4.1 and 4.2 take a closer look at different financial risk management tools tailored to health-related financial needs. Section 4.3 provides examples of non-financial services by FSPs to tackle health risk. More detailed accounts of the examples can be found in Appendix 2.

4.1. HEALTH SAVINGS ACCOUNTS AND HEALTH LOANS

What are health savings accounts?

Health savings accounts are commitment savings products that can be only accessed with proof of a health need. They are primarily used to pay for frequent, small health expenses so that money is readily available when needed for a medical purpose (Reinsch et al.2010). The idea behind health savings accounts is to identify a savings objective and then create a disciplined approach that enables people to be prepared for health expenses. In a sense, clients are pre-financing or “self-insuring” against their own small health expenditure when opening health savings accounts.

These accounts are relatively common in some developed countries where they can be positioned to provide tax advantages to savers, but when targeting a market segment that is unlikely to pay income taxes, there needs to be other incentives to save. For example, the financial institutions could offer a more attractive interest rate and bonuses when depositors achieve their targets. Depositors could also qualify for discounts from health providers if paid for through the health savings account.

Health savings accounts should help clients manage smaller and relatively predictable health expenses. They would therefore be appropriate to manage the associated costs defined in Section 2. As illustrated in Box 3, health savings accounts may also be appropriate to cover relatively low-cost outpatient services, such as inexpensive preventative care, minor illnesses and routine care.

BOX 3. Health Savings accounts from RCPB in Burkina Faso

Réseau des Caisses Populaires du Burkina Faso (RCPB), a microfinance organisation in Burkina Faso, developed three solutions to address the health needs of its clients:

a voluntary health savings product;

a health loan (only accessible if the health savings account has been depleted, or if the active account has exceeded the capitalization period and a verifiable major health cost has emerged); and

a health solidarity fund managed by RCPB to invest in health protection services in communities served.

Clients deposit a minimum of USD 1 per month into a special savings account designated only for health expenses. During the first six months (or until a minimum of USD 20 is accumulated, whichever comes first), the client may not access these funds. Clients may then withdraw health savings upon presenting proof of health expenses for the client or any family member (e.g. a receipt or a doctor's order).

The health savings do not earn interest. The interest charged on the health loans is less than that charged on RCPB's microenterprise loans. Health loans also carry more flexible repayment terms. The intention is to deter the use of other loans or borrowing to address health issues. It is hoped that RCPB clients are better positioned to have the small funds needed to address everyday health expenses before they become more serious, and to access affordable credit to pay for treatment when their health savings do not suffice.

Research done by Leatherman et al. (2011) revealed that members with access to the health savings account were 2.6 times more likely to report feeling satisfied with their preparations to meet future health expenses and were 3.7 times more likely to feel confident that they would be able to save for future healthcare expenses. In addition, clients seeking preventative health care increased from 9 percent to 24 percent amongst those with access to health saving and health loan accounts (Metcalfe et al., 2010).

Another study of RCPBs Health Savings and Loan product by Gray and Gash in 2016 reported that clients were overwhelmingly pleased with their health savings accounts, even when they had regular savings accounts, because the health account allowed them to build savings specifically for health and created savings discipline for costs they knew they would eventually incur. They also appreciated that they could keep their health problems more private by not having to borrow from family members or neighbours. When households had access to health savings accounts, long-term health costs were less than when households did not have a health savings account.

Adapted from: Gray and Gash, 2016; Leatherman et al., 2011.

Having a health savings account should help clients avoid borrowing from friends and family, or moneylenders. While health savings are unlikely to be sufficient to cover serious health shocks, allowing clients to address minor health issues earlier helps guard against the risk of delaying care until a health problem becomes more serious, thereby averting heavier financial strain on the household. As shown in the example of RCPB in Burkina Faso, the overall health expenses for clients with health savings accounts was lower than those without, suggesting that the former sought treatment earlier and therefore avoided more serious illnesses.

Design considerations for health savings accounts

When designing health savings accounts, there are some important issues to consider, such as:

- **Regular payments:** The goal should be to create a mechanism that allows clients to deposit a fixed amount regularly into their health savings account, at least until they reach a target or threshold amount. However, given the irregular cash flows of this market segment, it may be difficult to achieve that objective, so it is important to consider what sort of incentives and penalties will be used to promote disciplined payments, with an emphasis on incentives.
- **Incentives to save:** To encourage clients to save regularly, it might be possible to offer a slightly higher interest rate for consistent payments, or to pay a bonus once depositors achieve their savings goal. It also may be possible to consider penalties if clients do not deposit regularly, but that is unlikely to be well received by clients.
- **Value-added services:** It is useful to consider the health savings account as a platform on which the FSP can add other health-related services. As discussed in Section 4.3, these could include a dial-a-doctor service, pharmacy discounts, or health advice.
- **Withdrawal restrictions:** For the health savings account to have integrity, it needs to be illiquid and only utilized for an actual health expense. But does that include transportation to the hospital, or pharmaceuticals, or consultations with traditional healers? What constitutes such an expense will need to be negotiated between the FSP and its clients upfront so that everyone is clear what is and is not included. Payment could then be made either directly to the healthcare provider, or withdrawals can be allowed when they show a valid medical receipt or invoice.
- **Who is included?** It is also important to stipulate upfront whose medical expenses should be included in the health savings account. Ideally, it should include anyone that the depositor will have an obligation to pay for, but that could be a long list.

Ultimately it is the clients' money in the account, and they should use it when they need it, ideally for health, but there is not a need to validate "claims" from the savings in the same way one would for insurance because clients cannot really defraud themselves.

What are health loans?

Even when clients have a savings account, they may prefer to not to deplete it when faced with a health crisis, as described in Box 4. Essentially, savings serves as one of the final layers of resilience for low-income households, and if they use savings today, it will not be there tomorrow when they are likely to be hit by another event. Consequently, organizations should think about offering an emergency or health loan as well.

BOX 4. Savings versus credit?

Research conducted for the World Bank's World Development Report on risk found a somewhat surprising approach to the use of savings as a risk management tool. Clients often prefer to use other strategies if and when they have the option. Following the floods in Bangladesh, for example, the microfinance institution BRAC found savings withdrawals to be much less than expected, perhaps because saving was used as collateral, and clients were determined to keep their credit lines open. Several research studies find that people often prefer to borrow to cope with crises, rather than use savings, even though the loan comes at a cost and the savings are essentially free. Noponen and Kantor's study in India (1997) found that borrowing from a moneylender is actually more common in response to a shock than is using savings. Lund and Fafchamps (1997) found that people prefer informal loans even when they have precautionary savings. In Montgomery's (1996) hierarchy of coping strategies, calling in informal debts from kin and neighbours is ranked as a low-stress strategy, and the use of cash savings is ranked as a medium-stress strategy.

Source: Adapted from Sebstad and Cohen, 2000.

Health loans are appropriate for small to medium OP or IP expenses that cannot be covered through savings. Health loans provide access to finance for health intervention where otherwise the condition may be ignored and deteriorate. Furthermore, if the loan comes from a reputable organisation, this would help avoid high interest rates charged by informal money lenders. However, health loans may still place households under strain with repayments, and therefore they are generally unsuitable for very large health expenses that would cause over-indebtedness and additional mental and emotional stress.

Given that clients tend to use general savings as a last resort, and they like to use it as collateral for an emergency loan, it is useful to consider a joint approach. Health savings and loan accounts can be bundled together. As shown in Box 3, it is possible to combine the relative merits of each – saving for expected expenses and loans for unexpected ones.

Emergency loans can help clients in desperate situations, supporting them when they need it most. This is the case with AMK's emergency loan in Cambodia and is evidenced by the testimonial of Samnang, one of AMK's clients (see Box 5).

BOX 5. Emergency Loans – a client testimonial from AMK, a Cambodian MFI

"Five years ago, I was heavily pregnant with my second child. The sun had not yet risen when I was bleeding heavily. I remember how my heart sank when the village midwife told me that I needed to go to the provincial hospital for an emergency caesarean section. Welcoming a baby into the world is supposed to be a happy event, but without the USD 50 I needed for the operation, I feared for the worst. I knew they wouldn't even let me enter the hospital, let alone see the doctor. What could I do? As the contractions became more regular, all I could hear was the midwife's warning in my mind: 'You'll lose your baby, and your little girl might lose her mother too.' My family couldn't help me with the money but fortunately the neighbour, who had heard the commotion, came to the door. She was the president of the village bank, and reminded me that I could get an emergency loan from AMK. I had been in the group for more than six months, so I could apply. She lent me her phone, and even dialled the numbers because my hands were shaking so much. When I talked to the client officer, I couldn't believe what he was saying to me. I could have the loan. I didn't need to travel to the branch, I didn't even need to fill out any papers. He just said: 'Go to the hospital now. I'll meet you there with the money. The paperwork can wait.' And so I did. I still remember that somehow, that day, the distance between my village and the hospital in town had doubled – every bump on that long road caused me pain. I was in agony – but I was also full of hope and amazement at what had just happened. I wasn't going to lose my baby after all. It seemed like a dream. But sure enough, an hour later, I met the client officer on the steps of the hospital. He told me that he had already paid the money, and that they were waiting for me inside. And do you know? The client officer came back the next day to visit me and my beautiful new son. He was as proud as any uncle – and his eyes just shone when I told him that I decided to name my son 'AMK'."

Samnang (AMK client)

Source: Simanowitz and Knotts, 2015.

Emergency loans only for health expenses?

A key insight from *Portfolios of the Poor*, the seminal publication by Collins et al. (2009), is that day-to-day money management is one of the central financial concerns of poor households. There are many competing demands for cash and many possible reasons that could trigger the need for an emergency loan. A disadvantage of making emergency loans exclusively for health is that it cannot be used for other emergencies that may be equally as important. For the FSP, it may be an administrative burden to have too many emergency loans where each is for a specific emergency and having to verify that each trigger is genuine. Further, the FSP may have fewer clients using the product if its use is too narrowly defined. Consequently, some FSPs, like GFGS in Orissa, India, prefer to offer a more flexible product that can cover a range of emergencies, including health (see Box 6).

BOX 6. Emergency Loans used for health purposes – Hand Loans in India

Some financial service providers offer emergency loans that can be used for health purposes. An example of this is the “hand” loan offered by Dhanei KGFS, an FSP operating in Orissa, India. The product provides an easily accessible loan for customers to meet basic needs that they cannot afford in the immediate term. These could be for medical or education expenses, although the loan is flexible in its use.

According to a study by Financial Access Initiative (2011), the most common purpose mentioned by borrowers for using the product was meeting urgent health expenses. Not all such expenses were necessarily unexpected; illnesses and accidents are hard to foresee, but the same cannot always be said of childbirth. Nonetheless, a number of interviewees in the study reported having used Hand Loans to meet childbirth-related expenses.

Adapted from: Financial Access Initiative case study: Emergency (Hand) Loan. March 2011.

Having an emergency loan exclusively for health purposes, however, can also be advantageous as it ensures the funds are only used to access healthcare. By having a focused purpose, it can also help with branding, as illustrated in Box 7. The loan can also be better tailored to go that extra mile to help low-income households manage their health related financial needs. For example, a wellness element could be bundled with it, along with other financial and non-financial health related services such as telemedicine or a medical helpline. Health related discounts could also be negotiated and built into the product.

BOX 7. The digital health wallet with access to the national health scheme in Kenya, M-TIBA

M-TIBA, (where “M” stands for mobile and “Tiba” means care in Swahili), is a mobile ‘health wallet’ that allows people to save, borrow, and share money for healthcare at very low costs directly on a simple mobile phone. Money stored in M-TIBA can only be used to pay for treatment and medication at partner clinics and hospitals. It is described as M-Pesa (Kenya’s mobile money platform) which is locked for healthcare.

M-TIBA operates off a digital platform jointly developed by Safaricom, PharmAccess and CarePay to bring mobile phones and mobile money together to realise inclusive healthcare in Kenya.

With M-TIBA, it is possible to save for relatives, friends or employees. Funds stored in M-TIBA are managed by the insurance company, UAP Insurance. Donors and insurers can use M-TIBA to offer healthcare financing products, such as vouchers, managed funds and low-cost health insurance, directly to specific segments of the Kenyan population. M-TIBA promises transparency and accountability to all stakeholders involved, from the patient to the government.

M-TIBA started in 2014 with a pilot, giving 1,000 KSh (roughly USD 10) to low-income women, stating that it was only to be used for healthcare and observing what happened. Findings were that the “health savings” empowered the women and led to a degree of behavioural change around health issues.

The first M-TIBA product, the health wallet, was launched in July 2016 – a year later, almost 1 million Kenyans had signed up to M-TIBA. M-TIBA is widely available, with agents on the street. Given that it is a mobile application, there is also the opportunity for communication and dissemination of health information.

Source: Interview with PharmAccess, 2017.

Design considerations for health loans

Many of the design issues are similar to the savings accounts, particularly about eligibility and whether payments go directly to healthcare providers or to the clients, but there are some specific lending issues that need to be considered:

- **Eligibility and collateral:** Unlike savings where anyone can open up an account, when lending the FSP needs to be selective and only give emergency loans to clients that it thinks can repay. Consequently, it will have to establish eligibility criteria, which could include three main forms. First, existing clients with an acceptable credit history are eligible (for which “acceptable” needs to be defined); second, savings can be used as collateral allowing clients to borrow against accumulated balances; and third, if the FSP wants to broaden the outreach for this product, it could also include borrowers with co-signers who earn regular minimum salaries or who have excellent credit history.
- **Interest rate:** In general, the interest rate should not be lower than the FSPs core loan products as that might create an incentive for borrowers to get emergency loans instead.
- **Loan terms:** It is expected that these are typically short-term loans, but it depends on the household’s cash flow. If the borrower needs the funds for a serious medical condition that requires a long recovery period, during which time he or she is not earning an income, then

there may need to be a grace period before repayments are expected.

- **Timing:** Often these loans need to be made quickly as funds may be required in advance for people to receive medical treatment. Consequently, the ideal arrangement would be for people to be preapproved for funds, as in an emergency line of credit, which they could draw down if an emergency arises.
- **Rescheduling:** Another consideration is whether the loan applicant has an existing loan with the FSP, and if so, what are the implications? One of the objectives of the health loan is to protect the FSPs core loan portfolio, so if it is the borrower who is ill, it might be useful to consider providing a repayment holiday until the client is healthy enough to repay, and extending the original loan term.

The significance of healthcare finance made available for more minor conditions or earlier stages of illness through savings and loans provided by FSPs should not be understated; preventing the need for greater healthcare and expenditure downstream has considerable impact. However, health savings accounts and loans, while helpful for small expenses, are inadequate on their own to mitigate the risk of catastrophic health expenditure. This is because they lack a pooling and risk transfer mechanism. On average, healthcare is expensive and inevitably there are situations where personal savings, and perhaps even one's credit limit, are insufficient for the amounts needed for medical expenditure.

4.2. INSURANCE FOR HEALTH-RELATED EXPENSES

Any FSP considering the provision of insurance for health-related expenses should become familiar with the current and likely future national health context. This section focuses on insurance solutions that FSPs are using to help low-income households manage direct and indirect health expenses. The role of private health insurance for low-income people in the wider UHC context is discussed in Holtz et al. (2014) and is illustrated conceptually by Figure 5 in Appendix 1. Microinsurance, sometimes called mass insurance or insurance for emerging consumers, is insurance designed for low-income individuals or households.

Simple health microinsurance products

In the cases studied, health insurance for low-income populations tend to be very simple in their design. The majority of products labelled as “health insurance” are actually hospital cash products (see below). Different types of health microinsurance products can be defined by the benefit payment trigger (for example, staying at least two nights in a hospital as an inpatient) and whether the payment is a predefined sum of money, or whether it is indemnity insurance (i.e. it covers the actual cost of care, which could vary from claim to claim).

The different types of health microinsurance products observed include:

- **Hospital Cash:** This product pays out a predefined lump sum for either each night of stay in a hospital or per hospital episode. This is not an indemnity insurance, so it does not cover the actual cost of care. The lump sum is also not usually related to the cost of care while in hospital. The client will get the same amount of cash per night in hospital, or per hospital episode, regardless of the medical procedure performed. Ideally, members are already able to access tertiary care through government health schemes. The purpose of hospital cash is to help clients to manage their residual OOP expenses and possibly to help replace lost income. Examples of hospital cash products are Tonic in Bangladesh (see Box 8), Caregiver in Jordan (see Box 9) and the product jointly developed by Equity and Britam in Kenya (see Case Study 12).

- **A limited package of outpatient and/or inpatient cover:** An example of this type of scheme is ADéFI Santé in Madagascar (see Box 11). This product focuses on one set of procedures, for example maternity care or hospitalisation for a particular set of procedures. These types of products are useful to supplement government schemes. The costs and benefits of this type of cover should be compared against what is available from government schemes, as was done by PharmAccess in Kenya with its maternity pilot (see Box 10). The FSP should ensure that the product is viable, and clients are informed that they have not purchased comprehensive cover. At its most basic level, this type of cover could include primary care services delivered via telemedicine.
- **Lump sum cash pay-outs on the diagnosis of a particular disease:** This is similar to hospital cash, except the trigger is not a hospital stay, but the diagnosis of a particular disease or one of a set of diseases listed in the benefit schedule. An example of this is Pioneer's Mediacash Dengue Insurance in the Philippines. The benefits of Dengue Insurance is P 10,000 (around USD 200) medical cash assistance upon diagnosis of dengue fever for an annual premium of P 350 (around USD 7).
- **Personal accident and sickness policies:** These are policies which pay out when a member has an accident or sickness, which is usually predefined on the benefit schedule. With accidents, the amount of the lump sum paid out depends on, for example, the loss of limbs or eyesight. Common categorisation is for the benefits to be by death, permanent total disability and permanent partial disability, where each of these terms are clearly defined. This type of product could be used to cover workers in a particular industry for a set of perils, and could be useful where no government or enterprise-driven employment injury scheme is in place. The benefits could be lump sums or a set of regular payments. For example, Pioneer's Group Personal Accident policy pays out a lump sum on the occurrence of injuries incurred due to an accident.

These insurance products are often packaged with non-financial services detailed in Section 4.3. For example, the Tonic product offered by Grameenphone in Bangladesh (see Box 8), combines hospital cash with a range of additional benefits such as telemedicine, discounts with healthcare providers and lifestyle brands and health tips.

BOX 8. Tonic – a mobile phone delivered health package in Bangladesh

Tonic is a mobile phone distributed health microinsurance product (with other bundled health benefits) operating of a bespoke digital platform. It is offered to Grameenphone customers. Established in 2015, Telenor Health aims to use technology to help make quality health and wellness information, advice and services accessible to people, particularly in emerging markets.

Grameenphone is the largest mobile operator in Bangladesh, with 60 million mobile subscribers. With Grameenphone's link to Grameen Bank, and the bank's established position in microfinance, Grameenphone benefits from the Grameen brand when extending complementary products such as insurance and healthcare services.

Launched in June 2016, Tonic is seen by Telenor as the first step to scaling mobile health services to millions of consumers across Telenor's markets and beyond. Telenor expects Tonic to increase mobile average revenue per user (ARPU) and improve loyalty.

Benefits provided through the different Tonic packages include combinations of the following components – the degree of cover depends on the package:

Consultations and advice

- Personalised health content (SMS, app, web) including advice on preventative health
- Telemedicine, namely mobile-based consultations with doctors (calls and in-app chat) – called “Tonic Doctor”

Healthcare services

- Nationwide appointment booking service
- Discounts on health tests and specialist care, called “Tonic Discount”, through Tonic's country-wide network of partners providing discounts on services (health checks, labs, medications, procedures)

Financial coverage

- Hospital cash insurance called “Tonic Cash”

Different packages are on offer to Grameenphone customers:

1. Tonic Free (Basic version of Tonic – free aside from the cost of calls to Tonic Doctor)
2. Tonic Confidence (with a premium of Tk. 126/ USD 1.52 per person per month)
3. Tonic Protection (with a premium of Tk. 296 / USD 3.54 per person per month)

For more details on the benefit structure for these options, see the case study in Appendix 2.

As at March 2018, Tonic's membership had grown to 5.2 million freemium members since its launch in June 2016. There were also 750,000 paid customers, with 200,000 of these coming from corporate accounts.

Source: GSMA Intelligence (June 2017), *Conversations with Tonic* and <https://mytonic.com> – information as at December 2017.

BOX 9. Health microinsurance in Jordan offered by the MicroFund for Women – Afitna

In 2010, Jordan's Microfund for Women (MFW) piloted "Caregiver," the country's first private health microinsurance offering, in partnership with Women's World Banking. A summary of the premiums and benefits as at 2012 is given in Table 1.

Table 1. MicroFund for Women's Caregiver product features at a glance

Premium	USD 1.5 per month (payable with regularly scheduled instalments of loan repayments)
Hospital benefit	USD 14 per night, up to 30 consecutive nights or 45 nights over the course of the term (usually 12 months) of their loan. An average hospital stay is 3 days.
Other features	Caregiver benefits can be used to cover indirect expenses associated with illness or hospitalization. The most critical of these allowed expenses is the lost income clients experience when they must suspend their business operations. But other indirect expenses covered include transportation to and from the hospital, meals, and other incidentals.
Exclusions	None. MFW clients are automatically covered when they take a new loan. There are no medical examinations and no rejections for pre-existing conditions.
Deductibles, co-pays, limits per incident, total limits	Maximum 45 days per term

According to a paper published by Women's World Banking in 2012, the Caregiver pilot "succeeded beyond expectations". Caregiver was mandatory for all MFW clients as a condition of access to credit. This meant that there was a risk clients would go elsewhere, however the product was accepted. Key success factors included:

- a) Careful planning and extensive pre-launch research.
- b) The decision to offer "gap" coverage. For many clients, especially in Jordan, a country that has reasonable healthcare infrastructure, the direct costs of care do not necessarily represent the only, or even the largest, financial burden. Of much greater consequence is the potential lost income as the entrepreneur deals with a health crisis.

The success of Caregiver led to the full launch of the product, which over time changed its name to Afitna. It is still mandatory for all clients. As at February 2018, over 125,000 clients are covered, which translates to 478,000 insured lives when including clients, their spouses and children. In an interview with Women's World Banking in 2018, the question was asked: the product has now been going for six years – what makes the product sustainable? The following was cited:

- a) solid pricing
- b) thought partnership with the insurer
- c) streamlined claims operations at MFW's end, and
- d) deep engagement with the clients.

Source: Women's World Banking and Credit Suisse paper (2012) and telephone interview in 2018.

As stated in an earlier section, an understanding of the health system is necessary to benchmark any new product under development. With the financial pooling power of large government schemes, it is usually hard for smaller schemes to offer value for money. This was the case for M-TIBA in Kenya (see Box 10).

BOX 10. M-TIBA's maternity care pilot, Kenya

PharmAccess launched a pilot in 2016 where 50,000 people living in the slums of Nairobi were given access to a health insurance product providing outpatient and maternal care. The pilot was a huge success and after the initial flurry of pent up health needs were addressed, utilisation rates stabilized after about a year. The healthcare cost per patient per month, however, was similar to the capitation fee of the National Hospital Insurance Fund (NHIF), which offered a far more comprehensive cover than the pilot. It therefore made sense to transfer these clients to the NHIF scheme (around USD 6 per family, per month). This highlights the power of national risk pooling to provide affordable comprehensive health cover; private insurance should rather aim to cover the health needs that are not already met through a national scheme.

Source: Interview with PharmAccess in 2017.

Advantages and disadvantages of insurance

Insurance provides risk pooling for members of a scheme. Insurance therefore has an advantage over savings and loan products, potentially covering larger expenses than one might be able to afford on their own. However, insurance by itself also tends to be restrictive, for example where the member cannot afford the premium or where the cover is not comprehensive.

FSPs could combine insurance with savings and/or credit. MicroEnsure piloted a product in 2016 called Fearless Health in Kenya, which bundled an emergency health loan with hospital cash (see Appendix 2 for more information on Fearless Health). Unfortunately, the right distribution approach was not found for this product and the product was not launched, however, MicroEnsure continues to innovate around the idea of combining insurance with savings and credit.

An operational challenge for financial services providers is that insurance is not their core expertise, and they are often prohibited from underwriting insurance themselves. Consequently, the preferred model is for FSPs to partner with insurance companies, and offer the product to their clients as an insurance agent. This institutional arrangement has the potential to be a win-win-win scenario for insurers, FSPs and their clients, but managing the institutional relationships can sometimes be difficult. For more details about developing effective collaborations between FSPs and insurers, see Rendek (2012) and Churchill et al. (2012).

Limitations of private health insurance for low-income households

Despite the warnings, there is still the temptation for insurers to take private health insurance products aimed at middle- to high-income market segments, reduce the benefits and the premiums, and then attempt to sell this to low-income clients. This is dangerous because if it is affordable for the low-income population, it is likely to not be comprehensive, which then runs the risk of being misunderstood and mis-sold as something that is a substitute to government health cover. It is better to build the solutions from the ground up, being mindful of the health context. Of key importance is to manage the clients' expectations and treat them fairly. This means being realistic about what can and cannot be covered (doing the appropriate actuarial modelling), and then clearly stating the benefits so that so that the products are not mis-sold. It is common to find that some clients think they have fully comprehensive cover even with a hospital cash product.

Furthermore, the ILO's research shows that market-based comprehensive health insurance for the working poor struggles to reach scale and, without government subsidy, is unlikely to be sustainable (Weilant, 2015). In contrast, the health insurance products that do reach scale and are successful, are not comprehensive (e.g. hospital cash plans), and therefore are also unable to mitigate the risk of massive catastrophic health expenditure. That is not to say there is no role for private health insurance; mitigating financial risks such as the inability to pay for transportation to the nearest clinic or for medication can still have a profound impact on a low-income household.

Institutional arrangements for insurance

For most FSPs, their core business is providing banking services – savings, loans and payments. Insurance is quite a different financial service, and is required by most regulatory agencies to be managed separately from banking. Consequently, the vast majority of FSPs that offer health insurance do so in partnership with insurance companies. For example, Pioneer's Dengue Insurance product is distributed through partnering MFIs in the Philippines. In these cases, the FSP is essentially a distribution channel for the insurance company, which enables the former to provide its clients with valuable services without assuming the risk. In exchange for its efforts, the FSP will often earn a commission.

One challenge of this arrangement, from the insurer's perspective, is that the FSP may decide to shop around and get a better deal from another insurer. If the FSP has a particularly large client base, since it has a captive market, it can drive hard bargains with insurers, which creates a disincentive for insurers to invest in the partnership. To overcome this challenge, CARD Bank in the Philippines decided that it would form a joint venture with its insurance partner, Pioneer. Together the two organizations formed CARD Pioneer MicroInsurance, which now distributes not just through CARD Bank, but through many MFIs (see Case Study 8).

Another uncommon model observed is to create a structure where a health mutual owns or has partial ownership of a linked MFI. In this model, the percentage of profits from the MFI is channelled into the health mutual, which in turn pays for the clients' health premiums. From the MFI clients' perspective, they are receiving premium-free health cover through the mutual. An example of this is ADéFI Santé, Madagascar (see Box 11). A significant limitation of this model is that one needs to have a loan to be eligible for health cover.

BOX 11. Where the Health Mutual owns the MFI, ADéFI Santé, Madagascar

ADéFI Santé is a Malagasy mutual health insurance program founded in 2009 that is linked to a large MFI called ACEP. ADéFI Santé provides premium-free insurance to 70,000 registered borrowers and family members with active loans from ACEP. ADéFI Santé offers a progressive coverage scheme that starts with 90 percent coverage of all IP medical costs for members and their families in the first loan year and progressively expands to include 70 percent coverage of all outpatient costs in the second loan year. Medications that are part of the ADéFI Santé formulary are covered with a cap of 15,000 Malagasy Ariary (USD 4.62) per prescription. ADéFI Santé is present in all provinces of Madagascar and is partnering with 110 clinical service providers.

ACEP Madagascar is one of Madagascar's oldest MFI and is focused on lending to SMEs in urban and peri-urban settings in Madagascar. It offers 12 to 15 months loans at low interest rates and has 21,829 active borrowers. There are 14 ACEP Madagascar agencies distributed throughout all six provinces in Madagascar. ACEP Madagascar is unique in that 40 percent of the institution is owned by ADéFI Santé, meaning that 40 percent of net revenue is channelled to ADéFI Santé. ACEP Madagascar has the largest and most comprehensive mutual health insurance scheme of any of Madagascar's MFIs.

Source: ADéFI Santé interview in 2017.

4.3. NON-FINANCIAL OR VALUE-ADDED HEALTH SERVICES

The financial services described in this paper - health savings, loans and insurance - are certainly important tools to manage health risks, but they are not sufficient. This section reviews five non-financial services that can be offered on a stand-alone basis, or better yet, bundled with any of the financial services for health, helping to make a more effective solution. These value-added services can be hugely beneficial to customers, making health knowledge more accessible and encouraging better health-seeking behaviours. Offering these services is becoming easier with advances in digital technology.

Value-added service 1: Reward schemes to incentivise healthier behaviour

The concept behind reward schemes is that financial incentives are used as a reward to encourage clients to behave in a desired way. In the context of health, clients would be rewarded (financially or otherwise) for healthy behaviour. The theory is that much of illness is related to unhealthy lifestyle that is within our control, for example what we eat, how much we exercise, and whether we make use of available preventative care. Thus, by behaving in a healthier way, the chances of falling ill are reduced. This is obviously good news for insurers wanting to keep their claims costs down and other FSPs, who want healthy savers and borrowers. Further, reward schemes can not only actively engage members to take more responsibility for their health, but can also foster client loyalty. This is the case for Vitality, the reward scheme started by Discovery Health in South Africa, which has attained global success and has been attached as a “shared value”¹ programme to different insurance and credit card services (for more information, see Box 12 and Case Study 15).

¹ “Shared-value” in this context, is defined as a framework to create economic value, while at the same time addressing a societal need. The concept is that business models can and must address social issues at profit. (Porter and Kramer, 2011).

BOX 12. Vitality and The Tiko Health Companion – examples of reward based schemes

The **Vitality** scheme, developed by Discovery Health in South Africa over 25 years ago, is the world's longest-standing incentive-based health promotion programme, with nearly 4 million members worldwide. While this is a scheme designed for the middle- to high- income populations, the approach could be adapted to the low-income market segment. The Vitality scheme works as follows: if you go to one of the participating gyms, you earn points; the more frequently you go, the more points you earn. Points are also rewarded for other health-seeking activities. The number of points you have determines your Vitality status. As your status improves, you receive increasing discounts on your insurance premiums and access to other related benefits, e.g. discounts on gym clothing and health spas. According to research by Jais et al. (2017), there is evidence that the Vitality scheme can change members' behaviours and possibly makes them healthier. The study, also referenced in an article for the Harvard Business Review, showed that Vitality members generate up to 30 percent lower hospitalization costs. For more on Vitality, see Appendix 2.

An example of a reward scheme in the low-income context is the digital application developed by Triggerise called "The Tiko Health Companion". Triggerise, a not-for-profit development organisation operating in 12 markets in Sub-Saharan Africa and India, believes that people should be "rewarded for doing the right thing" and that rewarding people is an efficient way of driving social impact. With its tongue-in-cheek website, Triggerise makes the point that changing peoples' behaviour is not just about making products better or information available. According to Triggerise, "a better condom will not address the fact that people are embarrassed to buy condoms or that they don't trust them. That awesome app containing all information about malaria will not make a lot of people use nets regularly. It simply won't. That comprehensive policy on nutrition will not change the fact that people will continue to eat whatever they are used to eating."

Like Vitality, Triggerise has developed reward platforms aimed at changing people's behaviours. For example, "Tiko Saathi" is a prepaid pregnancy insurance scheme in India. For INR 500 (around USD 7.80), members are guided through their pregnancy. Each time a milestone is reached, such as going to an antenatal visit, the member is rewarded with Tiko points. Extra Tiko points are awarded if milestones are reached in a particular timeframe. If all milestones are reached, then the member is entitled to a free delivery, even if it is a C-section. Tiko points can also be redeemed at participating shops and service providers for items such as vitamins, healthy food and even at selected hair salons. Once the child is delivered, rewards can be used to upgrade to other "Companions", such as "The First Year Companion", which helps navigate immunization, nutrition and stimulation for a child during the first year. There are other Companions, for example for Hypertension and Diabetes. All Tiko points earned are exchangeable, so they can be spent, traded or saved. This creates a virtual economy for a cash-starved market.

Source: Jais et al. (2017) and information from the following websites, as at December 2017 - <https://www.discovery.co.za/vitality/join-today>; <https://www.vitality.co.uk/careers/our-history/>; <https://triggerise.org/>; and <http://sharedvalueinsurance.com.t>

While there appears to be evidence that FSPs have the potential to change the way their clients behave with interactive reward-based games, not many examples target low-income households. There is great opportunity for further experimentation of bundling reward schemes with financial services, thereby aligning the incentives of clients and FSPs.

Value-added service 2: Telemedicine

Telemedicine is defined by the European Commission as “healthcare services, through the use of information and communication technology, in situations where the health professional and the patient are not in the same location. It involves the secure transmission of medical data relating to prevention, diagnosis, treatment and follow-up consultations”. Telemedicine ranges from simple medical help-lines to diagnostics and the delivery of care over the phone. The main example of telemedicine as part of an insurance offering is Tonic in Bangladesh (see Box 8).

Historically, many of the telemedicine products have been medical hotlines, also known as dial-a-doctor services, rather than fully-fledged services complete with diagnosis, provision of prescriptions and follow-up. Since the early 2000s a number of health hotline services have emerged, for example Safaricom’s Daktri 1525 in Kenya, MedcallHome in Mexico and Hello Doctor in South Africa.

Telemedicine offers convenient medical care to the emerging consumer, as less time is wasted traveling to clinics and waiting in anterooms and critically, less time is needed away from work, which is especially important for those working in the informal sector where time away from work means lost income. Telemedicine also offers the possibility of extending access to specialists in resource-poor settings, which is advantageous in remote areas. Clients also have the advantage of being able to address topics with privacy during extended hours. Ultimately telemedicine can support efforts to achieve UHC given the dramatic shortage of healthcare workers in developing countries and especially in rural areas. It may also be cheaper to provide care through telemedicine than in person. There are, however, also barriers to overcome, for example accepting the loss of human interaction.

From the FSPs perspective, combining telemedicine as a value-added service to financial products has a number of advantages. It helps to differentiate product offerings from competitors, foster loyalty (where clients appreciate the service) and tap into emerging consumer markets where, with the lack of medical infrastructure, there is a tremendous need for health solutions. While telemedicine cannot be the solution for all health conditions, it has been proven to be very effective for certain advice (for example sexual health, dermatology and mental health). In fact, the bulk of telemedicine consultations lead to self-treatment and immediate solutions for the customer without subsequent need for further medical consultations.

Value-added service 3: Health information and mobile applications

Providing health information, public health alerts and education on how to manage personal finances (particularly health related expenses) are important non-financial benefits, especially to low-income persons who may not have received this education through school or at home, and who have the toughest job of managing from day-to-day on a small budget. There are other ways of providing educational information, but the main focus in this section is digitally delivered messaging. It is important to do the necessary market research and ensure that the messaging is done in local languages and that the audience has sufficient literacy to read the messages. An alternative to SMS are voice messages, again in local languages.

Many mobile phone health applications exist, providing health tips on exercise, diet, sleep, maternity care, managing particular diseases, and work-life balance among other things. The use of these apps depends on whether they are designed for the target market. As noted by behavioural economists, information that is presented without anything that engages the user, or without some kind of reward, may not be used.

Other applications popular in the low-income market are apps that help source qualified doctors and reputable clinics, and can verify whether medication is genuine. Counterfeit drugs are a big problem in many developing countries. For example, in Nigeria there are helplines whereby customers can call and

check codes to ensure they are not buying fake drugs. In Kenya, there are also helplines and online apps to check that your doctor, nurse or clinical practitioner is not a “dodgy doctor”. With the Dodgy Doctor app, you can check to see where they are registered. Packaging these services together with health related financial services makes it easier for clients to access the information they need to make educated health decisions.

Value-added service 4: Recommended healthcare providers

Clients are usually worried about two main things when it comes to healthcare: quality and cost. On the quality side, they want some assurance that the medical professionals treating them are qualified and competent. As for the cost, they want to know whether they are being charged a fair price, especially if they are paying for part or all of the services.

Providing a means of assessing healthcare providers so that there is some guidance towards higher quality services is therefore a valuable service that provides clients with some peace of mind. This can be done, for example, by compiling a network of approved and accredited providers. Further, FSPs can help by negotiating discounts on behalf of their clients within a network of pharmacies, clinics and health related retailers. FSPs have the power to negotiate favourable group rates for members based on higher volumes of patients and increased pharmacy or shop footfall.

Those offering microinsurance tend to be familiar with accredited provider lists and discounts as value-added services. Tonic in Bangladesh (see Box 8) bundles a hospital cash microinsurance product with negotiated discounts at pharmacies and retailers along with a number of other benefits. Likewise, FSPs offering health savings and loans could include discounts and a recommended health provider network, especially if the financial institution was paying the health care providers directly. For example, in the Philippines, CARD has organized discounts for its members at preferred health care providers (see Box 13). Discounts can be used as an incentive to save; for example, if you use pay the provider from your health savings account, then you are entitled to discounts within the specified network.

BOX 13. CARD - organising a network of health providers for clients in the Philippines

The Center for Agriculture and Rural Development (CARD) in the Philippines established a network of private healthcare providers, available through the “Healthy Pinoy” membership card, which entitles CARD members to discounts of 10 percent to 40 percent on primary and diagnostic healthcare services offered by physicians, dentists, hospitals, laboratories, optometrists and midwives. The CARD staff assessed basic aspects of quality before signing up providers. By the end of 2010, CARD clients and family members were making approximately 10,000 visits per year to CARD’s “Healthy Pinoy” providers.

Source: Leatherman et al. (2011).

Value-added service 5: Direct investments into clients' health

Some FSPs go beyond offering health related financial services and invest directly into the health of their client base. They do this in a number of ways, including:

- Health and nutritional literacy activities
- Health screening camps
- Awareness raising
- Healthcare services, for example camps and clinics

Many FSPs provide financial services to groups of clients, who mutually guarantee each other's loans. Regular group meetings offer excellent opportunities for the provision of add-on services, such as training in health and financial literacy. FSPs may be involved in supporting their clients' health because it is aligned with their social agenda, but there may also be a business case for doing so. An example of a FSP offering their clients direct access to health care is Equitas Bank in India (see Box 14). Sometimes these activities may not be directly financed by the FSP, but through affiliated NGOs (see Box 15).

BOX 14. Equitas Bank - Setting up health camps in India

Equitas is an MFI operating in India, providing financial services to individuals and MSEs underserved by formal financing channels. One of the main reasons for over indebtedness amongst low-income households in India is unforeseen health expenses. In response, Equitas has been conducting health screening camps since 2008. As at 2017, Equitas' health services have cumulatively benefited over 4.5 million clients.

Health services offered at these camps include:

- **Primary health care:** for all MFI clients, including the distribution of spectacles and performing cataract operations free of charge. Equitas also arranged for evening clinics for doctor consultations.
- **Secondary health care:** through an agreement with a network of hospitals to provide treatment for serious illnesses at a discount.
- **Health helpline:** dedicated line for serious illness and the operator connects them to network hospitals
- **Equitas sugam clinics:** evening consultation clinics in slums and villages.
- **Health education:** 5-hour health education module developed by Freedom from Hunger & Results, which enables women to easily learn early detection methods of non-communicable diseases. This is imparted to around 50,000 women each year.

Equitas allocates a monthly budget of Rs.2000 (USD 50) per branch to conduct its camps, which it believes it recoups through corresponding improvements to its loan portfolio from healthier customers.

Source: Interview with Equitas, 2017.

BOX 15. The Grameen Foundation - Investing in health education

An example of an NGO using MFIs as a vehicle for improving the health awareness and financial literacy of low-income clients is the Grameen Foundation. Interventions include interactive sessions on topics such as prenatal health, safe birth, nutrition, common childhood illnesses, malaria, HIV/AIDS, prevention of non-communicable diseases and water and sanitation. Through their projects with MFIs, they also train poor women on coping with health-related financial shocks, planning ahead, how to use available health financing tools and health services, including health microinsurance. These interventions are integrated with behaviour change communication messages. Their observation is that behaviour change communication messaging is best linked to products and services for successful and long-lasting behaviour change. This concurs with the experience of Triggerise.

For more information on the work of the Grameen Foundation, see Case Study 2: Improving Health Access in Rural Areas through Savings Groups, Benin and Case Study 3: Cooprogreso, Ecuador.

Source: Interviews with the Grameen Foundation, 2017.

5. Coordination with government programmes

Given that an increasing number of governments are investing in UHC, it is an opportune time for FSPs to support government-led health schemes in their quest to reach all citizens. This is beneficial to FSPs for a range of reasons including the opportunity to improve the health of their clients, while potentially enhancing customer loyalty and generating a new source of income.

There are a range of ways FSPs might coordinate with national schemes, beginning with the wellness programmes, such as health camps and reward-based schemes described in the previous section, which could be coordinated with government efforts. Another approach is to offer financing with special terms to government (or private) healthcare providers to invest in medical equipment, facility improvements, technology and research. If it has a government contract, then the local healthcare provider could be a low-risk borrower.

But perhaps the main way that a FSPs can link with government schemes is by acting as an agent to support enrolment and possibly assisting with premium financing. Historically government schemes have focused on workers in the formal sector, and they often do not have the right mechanisms to register or enrol workers in the informal economy. Schemes like the National Health Insurance Scheme (NHIS) in Ghana or National Hospital Insurance Fund (NHIF) in Kenya may be fully subsidized for the poorest population segments and various high risk groups, such as the elderly or pregnant women. However, for workers in informal sector who are not sufficiently poor, they need to be encouraged to enrol and to make a contribution to participate in the scheme.

Typically, there are three obstacles to enrolment: awareness, trust and affordability. Often the target group is not familiar with the scheme and may not know where to go to enrol. If they are aware, they may not trust that the scheme will really provide the benefits that it promises. And even if they want to enrol, they may not have the annual contribution readily available. All three of these obstacles are tailor-made for an FSP that engages regularly with this target group, has their trust, and can help finance the premium. As illustrated in Box 16, CARD has adopted this approach.

BOX 16. CARD - linking with the national health scheme in the Philippines (PhilHealth)

In the Philippines, CARD tested a partner-agent model of “health microinsurance”, which in this instance was enrolment into the national hospitalization insurance program, PhilHealth. CARD promoted and facilitated optional group enrolment for its clients in PhilHealth and provided a loan to cover the USD 26 annual premium so that clients could pay in small, weekly instalments. CARD charged 24 percent interest (flat, annual rate on par with CARD’s regular business loan rates) on the PhilHealth premium loan, plus a 1.5 percent Loan Redemption Fund fee. The resulting payment of about USD 0.60 per week was added to the member’s regular business loan and savings deposit payment, which was made at regular credit group meetings. CARD received a 9.7 percent discount from PhilHealth on the premiums, providing a margin that helped cover management costs. Interviews conducted by CARD with 40 randomly selected members who had enrolled in PhilHealth showed that they were overwhelmingly happy with the cover and that it had helped cover the financial health needs for a significant proportion of those interviewed. CARD’s microinsurance premium loan product was initially not profitable, but became so as it reached scale.

Source: Leatherman et al. (2011).

FSPs could integrate or bundle government health cover with other financial services in addition to offering just the enrolment service. A link with health savings accounts is particularly interesting since the

account could be used to pay the premium or ancillary health costs not covered by the national health programme. A successful example of this is M-TIBA in Kenya whereby the M-TIBA savings platform also allows users to enrol into Kenya's NHIF (see Box 7 and Box 10). FSPs that offer health insurance plans would want to design their benefit package as a complement to the government scheme, to fill in gaps, for example for pharmaceuticals or to cover lost income.

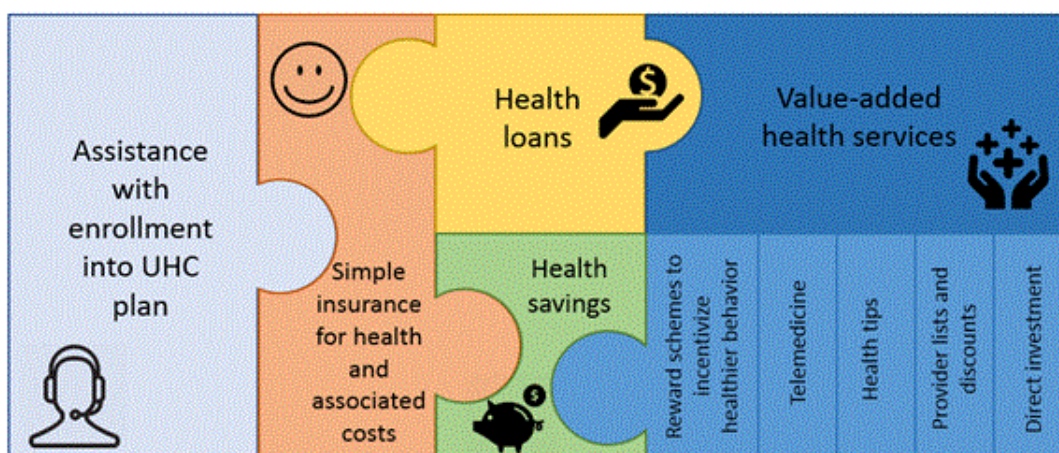
6. Closing thoughts on financial inclusion and health

Studies by Leatherman et al. (2011) and Freedom from Hunger (2014) revealed that by offering health protection services and products:

- A significant number of clients were seeing a doctor for the very first time
- Clients, on average, tended to seek a higher degree of preventative care and are overall more mindful of their health needs
- Some health protection products were profitable for the MFI
- There is evidence of increased client growth and retention

Given this evidence, the demand and relative lack of supply, there is an important opportunity for FSPs to create integrated health solutions for the populations they serve. As illustrated by Figure 4, there are many pieces to the puzzle. Packages that combine access to government health schemes with health savings, loans, health insurance, and relevant value-added services could make a significant contribution to combatting the cycle of poverty by helping households and MSEs manage their health risks.

Figure 4. The full package of health interventions for FSPs



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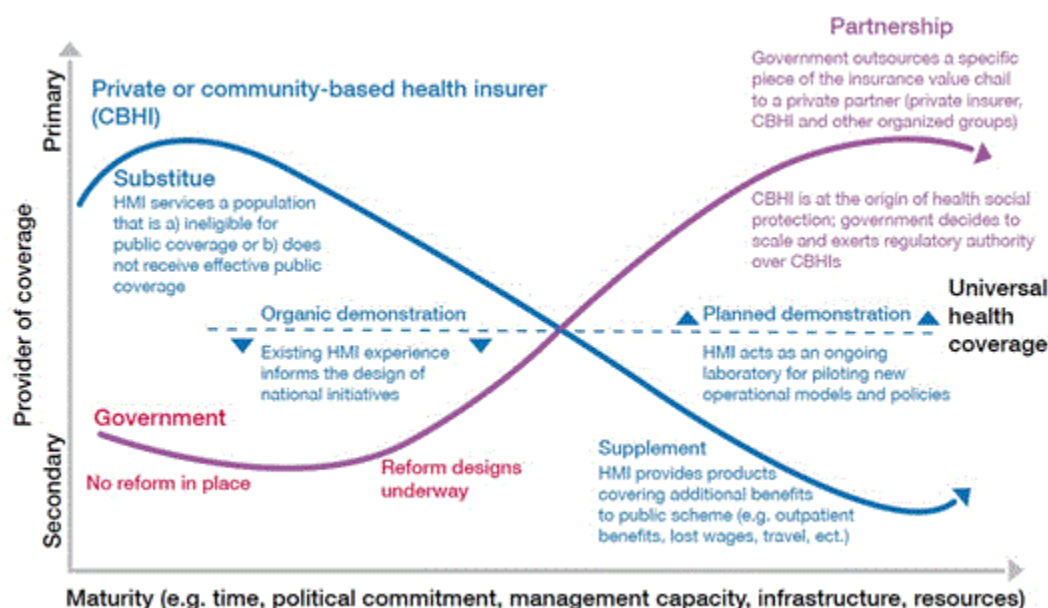
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APPENDIX 1: THE ROLE OF FINANCIAL SERVICE PROVIDERS IN UHC AND THE UN'S SDGS

Prior analysis by the ILO's Impact Insurance Facility indicates that there are two broad areas in which FSPs can operate in the wider UHC context. One is through **supplementary activity** (for example, insurance products for lost income while ill, such as a "hospital cash" product) and the second is by **supporting or performing particular operational functions of public health programmes through public-private partnerships (PPPs)** (Holtz et al., 2014). An example of the latter would be an FSP that assists with enrolling members into a government health scheme (see Case Study 4 and Case Study 5) or a private partner that acts as the administrator to the government scheme. Utilising PPPs for development is incorporated in SDGs 17 (United Nations, 2017). As stated by the UN, the goal of PPPs is to exploit synergies in the joint innovative use of resources and in the application of management knowledge, with optimal attainment of the goals of all parties involved, where these goals could not be attained to the same extent without the other parties (KS et al., 2016). Figure 5 illustrates the development of health systems over time and how the financial sector (insurers and other FSPs) can engage with UHC once these schemes have reached a level of maturity. It should be kept in mind that the illustration below is simplified; health care systems are highly complex with many stakeholders involved in multiple capacities.

Figure 5. The role of health microinsurance in the expansion of Universal Health Coverage



Source: Kimball et al., 2013 and Holtz et al., 2014.

APPENDIX 2: CASE STUDIES

Case study	Brief description of health intervention
Case Study 1: Réseau des Caisses Populaires, Burkina Faso (RCPB)	Health savings accounts and conditional access to health loans
Case Study 2: Improving Health Access in Rural Areas through Savings Groups, Benin	Negotiated health benefits and health education for savings group members
Case Study 3: Cooprogreso, Ecuador	A health-oriented credit card for OOP expenses
Case Study 4: M-TIBA, Kenya	Digital platform connecting patients, payers and healthcare providers. Digital health savings account with option to enrol into the National Hospital Insurance Fund (NHIF), the government health scheme.
Case Study 5: CARD MRI, the Philippines – Part 1	Public-Private Partnerships between government and CARD MRI for enrolment into PhilHealth, government health scheme
Case Study 6: CARD MRI, the Philippines – Part 2	Public-Private Partnerships for maternal and child services
Case Study 7: Afitna, Jordan	MFI distributed health microinsurance
Case Study 8: Pioneer, Philippines	MFI distributed hospital cash product and dengue fever cover product
Case Study 9: SKS, India	Bundling of health microinsurance and health loan
Case Study 10: Fearless Health, Kenya	Bundling of hospital cash microinsurance and health loan
Case Study 11: ADéFI Santé, Madagascar	A health mutual with significant ownership in an MFI. Profits from MFI pay for health cover of client.
Case Study 12: Equity Bank group and Britam, Kenya	MNO distributed hospital cash microinsurance
Case Study 13: Equitas Bank, India	Direct investment from MFI into health of client
Case Study 14: Tonic, Bangladesh	MNO distributed hospital cash microinsurance and other value added services (telemedicine, health tips and discounts at hospitals, diagnostic centres and lifestyle outlets).
Case Study 15: Discovery Health's Vitality scheme, originating in South Africa	Longest running reward scheme to incentivise healthier behaviour. Example of a health value added services that could be bundled with savings, credit and insurance.

CASE STUDY 1: RÉSEAU DES CAISSES POPULAIRES, BURKINA FASO (RCPB)

Example of: a MFI providing health savings accounts and conditional access to health loans.

Description of organisation

RCPB is the oldest cooperative savings and credit network in Burkina Faso and one of the oldest networks in Africa. It is also the largest MFI in the country (Réseau des Caisses Populaires du Burkina, 2018).

Description of RCPB health savings and loan product

Freedom from Hunger, an international development organisation, ran a pilot initiative called “Microfinance and Health Protection” (MAHP) from 2006 to 2009, which continues today with their “integrated approach” to health activities (Freedom from Hunger, 2017). The goal of MAHP was to demonstrate the capacity of FSPs to design and deliver health products and services with positive health and economic impacts on clients, and remain financially viable. Réseau des Caisses Populaires du Burkina Faso (RCPB), was one of the MAHP partners (Gray and Gash, 2016b).

During the MAHP project, RCPB developed three products to address the health needs of its clients:

- i. a *health savings product*;
- ii. a *health loan* (only accessible if the health savings account has been depleted, or if the active account has exceeded the capitalization period and a verifiable major health cost has emerged); and
- iii. a *health solidarity fund* managed by RCPB to invest in health protection services for the communities served (Gray and Gash, 2016b)

How it works: The RCPB health savings product is voluntary. Clients agree to deposit a minimum amount of USD 1 per month into a special account designated for health expenses. During the first six months from opening the account (or until a minimum of USD 20 is accumulated, whichever comes first), the client may not access these funds. After this period, clients may withdraw health savings upon presenting proof of health expenses (e.g. a receipt or a doctor's order).

The health savings do not earn interest, but under the conditions described above, entitle clients to apply for a health loan in the case of a verifiable, major health cost for themselves or any family member.

The health loans come with a lower rate of interest (6 percent annual flat interest rate) than RCPB's microenterprise loans and carry more flexible repayment terms. The intention is to deter the use of other loans or borrowing to address health issues (Leatherman et al, 2011). With this package, it is hoped that RCPB clients are better positioned to have the small funds needed to address everyday health expenses before they become more serious, and to access affordable credit to pay for treatment if their health savings do not suffice (Gray and Gash, 2016a).

Experience to date

Research done by Leatherman et al. (2011) on randomly selected RCPB members with and without access to health savings and health loans revealed that members with access reported a greater use of preventive care than members without access, were 2.6 times more likely to feel satisfied with their preparations to meet future health expenses and were 3.7 times more likely to feel confident they would be able to save for future healthcare expenses. In addition, RCPB clients seeking preventative healthcare increased from 9 percent to 24 percent if they had access to the health saving and health loan accounts (Metcalf et al., 2010).

New insights based on a case study of RCPBs health savings and loan product were published in a working paper by Gray and Gash in January 2016 (Gray and Gash, 2016a). For the study, a diary approach was used with 46 women over a seven-month period to understand how they anticipated and managed financial shocks.

A second part of the 2016 study was an economic game, engaging 395 women, which was facilitated by researchers from the University of California, Davis. The game set out to observe the household decision making process regarding the choices the women make about allocating resources in hypothetical scenarios with and without the use of financial instruments designed to help people manage the risk of costly negative health shocks.

Key findings from the study are as follows:

- Between December 2009 and June 2013, a total of 19,500 health accounts were opened.
- Clients were overwhelmingly pleased with their health savings accounts, even if they had regular savings accounts with RCPB, because the health savings account allowed them to build savings specifically for health and created a level of savings discipline for costs they knew they would eventually incur.
- Clients could also keep their health problems more private by not having to borrow from family members or neighbours.
- Adapting/offering a health savings account to a group of clients proved to be challenging.
- The following are key success factors for managing health savings accounts for low-income clients:
 - **Timeliness** – Payouts must happen before households resort to missing meals or selling assets.
 - **Availability** – Money must be available for clients when they need it. There is often a need for urgent access to cash.
 - **Gender considerations** – The resilience research revealed that most (84 percent) of the women could not leave their homes without their husbands' permission. Follow-up qualitative research suggested that to leave the house for reasons other than those already approved (going to a scheduled village bank group meeting is likely an approved meeting), the women indicated they must wait for the right time to ask their husband (when he is in a good mood), to leave the home. If three women must travel on another woman's behalf to make a withdrawal, three women could also be waiting to ask permission to leave the house, adding time and complexity to the process.
 - **Lack of privacy** – For a village bank member to withdraw her savings, she must inform the management committee members of her group, who likely must ask their husbands for permission to leave and must explain and justify the reason for traveling. This would not allow a rural woman to keep her health matters private.
- Mobile technology can overcome some of the mobility/gender barriers above.
- A thorough understanding of the target market, in this case rural women and gender issues, is needed to appreciate whether products will work as intended.
- The economic game simulations showed that health savings accounts can provide a protective measure against small health shocks and build resilience over the long term.
 - Fewer households fell below the national or extreme poverty lines when they used health savings or loans. Overall, all households were better off with the health savings accounts.
 - Unlike health savings, while the use of health loans provided some level of access to healthcare, they did not prove to be protective over the long term.

- When households had access to health savings accounts, long-term health costs were less than when households did not have a health savings account; this is possibly accounted for by the fact that those with health savings accounts sought treatment earlier.

While the case study above shows a positive experience with a combination of health education, health savings and health loans to management risk, it should be kept in mind that such solutions are only intended for small health shocks.

Sources: Leatherman et al., 2011; Metcalfe et al., 2010; and Gray and Gash, 2016.

CASE STUDY 2: IMPROVING HEALTH ACCESS IN RURAL AREAS THROUGH SAVINGS GROUPS, BENIN

Example of: Negotiated health benefits and health education for savings group members

Description of organisations

Grameen Foundation is a global non-profit organisation that works to help poor families increase their income, build their financial security, and protect their health using innovative, technology-based approaches and local partner networks. Grameen Foundation's mission is to "enable the poor, especially women, to create a world without poverty and hunger." Their four key focal areas are:

1. Providing financial services
2. Strengthening smallholder farmers
3. Enhancing health, and
4. Strengthening organisations.

In 2016, Grameen Foundation and Freedom from Hunger joined forces under the banner of Grameen Foundation.

Combining Client education, Health Savings and Loans, Negotiating discounts from health providers, messaging for promotion of good health

In 2013, Grameen Foundation worked with two local NGO partners in southern Benin to introduce a health intervention package designed to increase access to health services through education and improve knowledge around health issues and care options, dedicated health financing and linkages to health providers. The initial target was 3,000 savings group members and their families. As at 2017, over 17,000 savings group members had access to health through negotiated benefits with 43 public and private health providers. Health savings and health loans are also available to pay for services through savings group.

Furthermore, the savings group members have become change agents, sharing health information they acquire during regularly held group meetings with others in their community. For example, after receiving information that regular hand washing with soap and clean water is the first line of defence from infectious diseases such as Ebola, diarrhoea and influenza, members decided to use a small amount of the group's health savings to purchase cleaning supplies such as soap, wash basins and bottles for clean water. The women also went to their children's school to talk about the importance of hand washing for disease prevention and set up hand washing stations at the school. Through this integrated health and financial

services initiative, women have demonstrated that given the right tools, they can protect their families' health and promote positive behaviour-change for their whole community.

Benin Family Planning

Another related initiative of Grameen Foundation in Benin is its family planning work, which is aimed at helping the government achieve its objective of 20 percent modern contraceptive prevalence by 2018.

The project works through women's savings groups and includes a behaviour-change communication campaign that raises awareness about family planning and reproductive health. It also includes men and community leaders in the discussion. It expands health financing options for savings group members to use for family planning services. Collaborations with local health providers facilitate access to health services, including appropriate family planning methods.

Source: www.grameenfoundation.org, www.grameenfoundation.org/where-we-work/sub-saharan-africa/b%C3%A9nin (information retrieved on 20th April 2018) and interviews with Grameen Foundation, 2018

CASE STUDY 3: COOPROGRESO, ECUADOR

Example of: A health-oriented credit card designed for OOP expenses

Description of organisation

Cooprogreso is a 50-year old financial cooperative in Ecuador offering financial services to around 150,000 members. It also supports vulnerable sectors of society through various social responsibility programs, such as its Health and Welfare program, which provides assistance to 8,000 people nationwide. Cooprogreso's mission is to "provide agile and inclusive financial solutions and services, through efficient and innovative processes, with state-of-the-art technology, to accompany entrepreneurial and productive activities, under the principles behind cooperatives and social responsibility, creating value for our partners, collaborators and customers".

Experience with the health-oriented credit card

Between 2013 and 2016, Grameen Foundation worked with Cooprogreso to develop and implement a system to link and integrate electronic payment services for health using Cooprogreso's existing consumer credit card. The goal was to improve access to health services through an electronic payment channel that enabled greater and earlier access to appropriate, local and referred healthcare providers by helping to cover direct and indirect OOP healthcare costs as needed. Over the course of the project, consumer credit cards with a health component were also made available to village-banking clients. At the start of the project, less than ten medical providers would accept the credit card. At the end of the project, the point-of-service systems had been expanded to an additional 586 health access points, including health and pharmaceutical clinics, hospitals, ophthalmologists, dentists and three different pharmaceutical chains.

Source: Information from Grameen Foundation, 2018

CASE STUDY 4: M-TIBA, KENYA

Example of: Digital platform connecting patients, payers and healthcare providers. Capacity for enrolling members into the National Hospital Insurance Fund (NHIF), government health scheme.

Description of organisation: M-TIBA is a digital platform jointly developed by Safaricom, PharmAccess and CarePay to bring mobile phones and mobile money together to realise inclusive healthcare in Kenya.

Description of scheme: M-TIBA, whereby the M stands for mobile and Tiba means care in Swahili, is a mobile 'health wallet' that allows people to save, borrow, and share money for healthcare at very low costs directly on a simple mobile phone. Money stored in M-TIBA can only be used to pay for treatment and medication at partner clinics and hospitals. It is described as M-Pesa which is locked for healthcare. With M-TIBA, it is possible to save for relatives, friends or employees. Funds stored in M-TIBA are managed by the insurance company, UAP Insurance. Donors and insurers can use M-TIBA to offer healthcare financing products, such as vouchers, managed funds and low cost health insurance, directly to specific segments of the Kenyan population. M-TIBA promises transparency and accountability to all stakeholders, from the patient to the government (PharmAccess Foundation, 2015, and M-TIBA, 2017).

The journey so far and key lessons learned: Unlike Uber, which is described as a two-way platform, M-TIBA is a three-way platform directly connecting patients, healthcare providers, and healthcare payers (insurers, donors and solidarity payers), and exchanges money and data between these three groups. M-TIBA started in 2014 with a pilot, giving 1,000 KSA to low-income women, stating that it was only to be used for healthcare and observing what happened. Findings were that the "health savings" empowered the women and led to a degree of behaviour change around health issues.

The first M-TIBA product, the health wallet, was launched in July 2016 – a year later, almost 1 million Kenyans had signed up to M-TIBA. M-TIBA is widely available, with agents on the street.

Another pilot was launched in the fourth quarter of 2016 during which 50,000 people living in the slums of Nairobi were given access to a health insurance product providing OP and maternal care. The pilot was a huge success and showed that after the initial flurry of pent up health needs were addressed, utilisation rates stabilized after about a year. The healthcare cost per patient per month, however, was similar to the capitation fee of the National Hospital Insurance Fund (NHIF), which offered a far more comprehensive cover. It therefore made sense to transfer these clients to the NHIF scheme (around USD 6 per family, per month). M-TIBA is therefore also acting as an agent to enrol low-income households into the government health scheme in Kenya. Beyond the NHIF, private insurance companies are also looking to use the platform.

One of the features of M-TIBA, which makes it fairly unique, is the promotion of social solidarity through easy money transfer. Users can save in their own wallets (which they can use for their family's health), they can receive money from more affluent relatives elsewhere, from donors, and even from individuals in other countries willing to donate directly for health. This new digital solidarity mechanism is engineered to support less formal risk transfer mechanisms from wealthier to poorer individuals, giving assurance that the money will actually be used for health.

The transparency generated by M-TIBA also makes it possible to identify vulnerable groups such as pregnant women living with HIV/AIDS in the slums, and place money or entitlements for treatment directly into their hands, on their mobile phones. Creating the trust that money is spent for the right person, for the right care, at the right place, at the right time, at very low transaction costs.

M-TIBA allows for the collection of health data in almost real time. Data privacy is taken very seriously.

As at July 2017, there were 400 approved healthcare centres in the M-TIBA provider network, primarily based in central and western Nairobi, however, there are plans for national roll out. Given the ability for users to choose and rate healthcare providers, this also puts the power in the hands of the patient. M-TIBA has already started changing the lives of some of the clients they serve. A testimonial is included in the box below.

M-TIBA client testimonial

Jecinter Anyango Kwanya works as a volunteer in the Kibera Health Center. She joined a chama that is saving for health using M-TIBA.

"If my baby is sick, or my husband, I can use the M-TIBA health wallet. Without it, I would have to borrow from a friend or a neighbor. That would not always work. If I couldn't borrow, I would go and talk to the doctor, asking him if he could help me and receive payment later. But now, I can pay.

In the chama, we save KES 1,000 (USD 10) per month. For the health wallet, we contribute 200 shillings and then get a KES 200 bonus.

Early this year, my two kids were seriously sick, and I went to the hospital with them. They did laboratory tests, and it came out they had typhoid. They got treatment and I paid 3,000 shillings for all that with the wallet. I am really happy that they are well now.

The wallet is very fine. I cannot spend that money on anything else. So if someone gets sick, I don't have to get stressed, because I have a little money to pay the bills."

Source: PharmAccess

In summary, there is potential for M-TIBA to be a game changer, providing a digital health wallet for savings, loans and transfers to deal with small shocks and access to the NHIF scheme for bigger health shocks. Given that it is a mobile application, there is also the opportunity for communication and dissemination of health information. It is exciting to see the realisation of a digital health concept taking off in a country where there is already a strong culture of mobile money, which could be one of the reasons for its acceptance.

Source: Interview with PharmAccess, 2017

CASE STUDY 5: CARD MRI, THE PHILIPPINES – PART 1

Example of: Public-Private Partnerships between government and CARD MRI

Description of organisation: Center for Agriculture and Rural Development (CARD) MRI (Mutually Reinforcing Institutions) is a conglomerate of related institutions in the Philippines that includes a large NGO offering microfinance services, two regulated microfinance banks, a training and development institute, a business development services arm, and an insurance company offering life, accident, disability, and property insurance. The PhilHealth insurance product described below was offered by CARD through the government KaSAPi programme for NGOs. This has been replaced by the iGroup program.

Description of solution and experience: CARD tested a partner-agent model of health microinsurance (here microinsurance referred to enrolment to PhilHealth, the national health insurance program). CARD promoted and facilitated optional group enrolment for its clients in PhilHealth and provided a loan to cover the USD 26 annual premium so that clients could pay in small, weekly instalments. CARD charged a 24 percent interest rate (flat, annual rate on par with CARD's regular business loan rates) on the PhilHealth premium loan, plus a 1.5 percent Loan Redemption Fund fee; adding about USD 0.60 per week to the member's regular business loan and savings deposit payment. CARD received a 9.7 percent discount from PhilHealth on the premiums, providing a margin that helps cover management costs. Feedback from members enrolled to PhilHealth was positive. A cost analysis (circ. 2008) of CARD's microinsurance

premium loan product showed an annual net gain to CARD of USD 0.57 per participating member (when allocated overhead costs are included).

The first PhilHealth Express Office was inaugurated on 1st July 2013 in their head office in San Pablo, Laguna to provide easy and fast access to PhilHealth cover. The Office provides services such as registration of PhilHealth Identification Number, processing of ID, generation of Member Data Record and general walk-in inquiries in the information booth every Tuesdays and Thursdays from 8:00AM to 5:00PM. It is open for CARD members/clients, staff, and the general public. The three main purposes for having a Philhealth Express site at CARD MRI premises are: relationship building, accessibility, and supporting women; PhilHealth and CARD MRI share the same mission to empower women.

Source: Leatherman et al, 2011 and CARD MRI's website <https://www.cardmri.com/?p=737>

<http://healthmarketinnovations.org/program/philhealth-kasapi-kalusugang-sigurado-abot-kaya-sa-philhealth-insurance>

CASE STUDY 6: CARD MRI, THE PHILIPPINES – PART 2

Example of: Public-Private Partnerships for maternal and child services

Grameen Foundation, together with CARD MRI in the Philippines, and the RESULTS Education Fund, designed the “Healthy Mothers, Healthy Babies” (HMHB, or Kalinga kay Inay, as it is known locally) initiative. It was implemented through CARD MRI's platform, which serves 3.3 million people across the Philippines. The initiative's goal was to improve awareness of maternal health services, enrolment to PhilHealth, knowledge of practices for a healthy pregnancy and safe delivery, and use of prenatal care and safe birth public and private services. It also focused on various components of a birth plan, such as planning for transportation, saving for birth-related costs and identifying the health facility.

Leveraging its financial services platform, CARD reached 800,000 women with maternal health education and 9,000 women with maternal health services through seven community health fairs, and collaborated with 160 individual health practitioners between 2014 and 2015. The program is ongoing. The HMHB initiative demonstrated the promise of multi-sectorial collaboration between CARD, the MFIs for Health consortium, local health providers—both public and private—and PhilHealth. In less than 18 months, CARD was able to mobilize a maternal health campaign that established relationships with health practitioners and health insurance providers with the promise of a continuum of care for hundreds of thousands of women and their families.

CASE STUDY 7: AFITNA, JORDAN

In 2010, Jordan's Microfund for Women (MFW) piloted “Caregiver,” the country's first private health microinsurance offering, in partnership with Women's World Banking. A summary of the premiums and benefits as at 2012 is given in Table 1.

Table 1. MicroFund for Women's Caregiver product features at a glance

Premium	USD 1.5 per month (payable with regularly scheduled instalments of loan repayments)
Hospital benefit	USD 14 per night, up to 30 consecutive nights or 45 nights over the course of the term (usually 12 months) of their loan. An average hospital stay is 3 days.
Other features	Caregiver benefits can be used to cover indirect expenses associated with illness or hospitalization. The most critical of these allowed expenses is the lost income clients experience when they must suspend their business operations. But other indirect expenses covered include transportation to and from the hospital, meals, and other incidentals.
Exclusions	None. MFW clients are automatically covered when they take a new loan. There are no medical examinations and no rejections for pre-existing conditions.
Deductibles, co-pays, limits per incident, total limits	Maximum 45 days per term

According to a paper published by Women's World Banking in 2012, the Caregiver pilot "succeeded beyond expectations". Caregiver was mandatory for all MFW clients as a condition of access to credit. This meant that there was a risk clients would go elsewhere, however the product was accepted. Key success factors included:

- a) Careful planning and extensive pre-launch research.
- b) The decision to offer "gap" coverage. For many clients, especially in Jordan, a country that has reasonable healthcare infrastructure, the direct costs of care do not necessarily represent the only, or even the largest, financial burden. Of much greater consequence is the potential lost income as the entrepreneur deals with a health crisis.

The success of the Caregiver led to the full launch of the product, which over time changed its name to Afitna. It is still mandatory for all clients. As at February 2018, over 125,000 clients are covered, which translates to 478,000 insured lives when including clients, their spouses and children. In an interview with Women's World Banking in 2018, the question was asked: the product has now been going for 6 years – what makes the product sustainable? The following was cited:

- a) solid pricing
- b) thought partnership with the insurer
- c) streamlined claims operations at MFW's end, and
- d) deep engagement with the clients.

Source: Women's World Banking and Credit Suisse paper, 2012 and telephone interview in 2018.

CASE STUDY 8: PIONEER, THE PHILIPPINES

Example of: a hospital cash product and dengue fever cover product, distributed through MFIs and others



BENEFIT DESCRIPTION	AMOUNT
Personal Accident	5,000
Daily Sickness Hospital Benefit (DSHB) / Daily Accident Hospital Benefit (DAHB)	200/day
Maximum of 15 days per year of combined DSHB and DAHB	

Description of organisation: Pioneer is an insurance company based in the Philippines. In 2007, Pioneer launched its first microinsurance offering covering 28,760 enrolments in the first year. By the end of 2016, enrolments reached over 18 million individual clients. In the same year Pioneer paid a total of 1 billion pesos worth of microinsurance claims. Pioneer is a partner to more than 60 institutions, including rural banks, cooperatives, microfinance organizations and other NGOs.

Description of products: Pioneer offers a range of microinsurance products offered covering a number of different risks. For this case study, the focus is on two health products – both are distributed by a number of distribution partners, including MFIs, pawnshops and Pioneer offices.

The first product, called CARD Care, combines personal accident and hospital cash benefits: P200 per day (around USD4 per day) in hospital (for a maximum of 15 days). This benefit is intended to be income assistance while hospitalised.

The second benefit is P5,000 (around USD 100) cash assistance in the event of accidental death.

The second product featured is Pioneer's Mediacash Dengue Insurance. The benefits of Dengue Insurance is P10,000 (around USD 200) Medical Cash Assistance upon diagnosis of Dengue Fever for an annual premium of P350 (around USD 7). Members need to download and fill in a simple claims form with their doctor.

Experience and lessons learned: Between the two products, around 150,000 individuals are insured. The products have been offered for 3 years. Regarding Pioneer's Mediacash Dengue Insurance, this product is complementary to the cover received through PhilHealth. PhilHealth provides care up to P10,000 (around USD 200 for grade 1-2 moderate dengue fever) and up to P 16,000 (around USD 308 for grade 3 severe dengue strains) for hospitalization cases due to Dengue fever. This product is supplementary and can be used for OOP expenses or to replace lost income, and is paid out on diagnosis, which means that the insured does not need to be hospitalised to receive the benefit.



PIONEER
Medi+cash
Dengue Insurance

P10,000
Medical Cash Assistance upon diagnosis of Dengue*

1 to 70
Years old may be insured

P350
1 Year Coverage

***EVEN WITHOUT HOSPITAL CONFINEMENT**

CHOOSE HOW YOU WANT TO GET INSURED

Fill out return stub, and drop in designated Pioneer drop boxes

or

Take a photo of the completed stub and email to retail@pioneer.com.ph or Viber to 0917 531 7213

or

Call 750 5433

or

Text 0917 531 7213 and we will call you

CASE STUDY 9: SKS, INDIA

Example of: Bundling loans and health microinsurance (Banerjee, Duflo and Hornbeck, 2014)

Description of organisation and products: Bharat Financial Inclusion Limited, (previously known as SKS Microfinance) offers life assurance and a variety of financial loans: Income Generation Loans; Mid-Term Loans; Long Term Loans; Loans for the purchase of products such as cook-stoves, solar lights, water purifiers, mobile phones, bicycles and sewing machines; and loans secured on gold jewellery.

In 2006, SKS Microfinance decided to offer health insurance to its clients. At the time, SKS was the largest MFI in India. The hope was that SKS would leverage its administrative advantage in dealing with low-income clients in rural areas of India and expand its product offering. SKS was also motivated to protect its loan portfolio from the risk of default caused by uninsured health expenditures. ICICI-Lombard provided the back-end insurance, while SKS administered enrolment and claims processing. The average health insurance policy cost INR 525 (approximately USD 8), which was added to the amount of the loan and paid in weekly instalments along with the loan payments. In comparison, the average loan amount was INR 8,300 (approximately USD 125). The health insurance policy was intended to be actuarially fair, although SKS was prepared to lose money initially on administrative costs. Due to concerns about moral hazard in health care usage, the insurance policy only covered hospitalization and maternity expenses. Clients had the option of going to approved health facilities for cashless treatment, or pay out of pocket for treatment at other facilities and submitting a claim for reimbursement.

Experience and lessons learned: The launch of the insurance product did not go smoothly. SKS initially planned to make the health insurance product mandatory for all existing clients. Due to client dissatisfaction, it was decided that purchasing insurance would only be mandatory for new clients or at the time of existing clients' loan renewal. Many clients still remained opposed to the requirement to purchase health insurance, despite an educational campaign to explain the benefits and persuade them otherwise. Discontent led to client drop-out. In October 2008, the health insurance product was made voluntary. This unilateral change to the insurance product, anecdotal accounts of adverse selection and outright fraud, led to a breakdown of relations between SKS and ICICI Lombard. Insurance enrolment was discontinued in March 2009.

The end line survey showed that very few people were able to claim the insurance benefit, largely because clients were never provided with the health insurance documents and cards needed to do so.

Failure to ensure positive customer experience impacted all involved: the insurer, distributor and, most importantly, clients. In the case of SKS, the majority of clients who dropped out lost access to microloans altogether, which hurt their businesses and livelihoods.

A key learning to be shared is that clients' experience of claims drives satisfaction and renewals. This is evident in the results of Microfund for Women (Jordan), which experienced steady (or in some branches, higher) renewal rates after the introduction of bundled insurance. The MFI paid special attention to claim procedures, investing in simplification, standardization, decentralization, and improving efficiency. An example of improving efficiency is establishing procedures that allowed the MFI to quickly authorize small claims on behalf of the insurer.

Source: Banerjee, Duflo and Hornbeck, 2014

CASE STUDY 10: FEARLESS HEALTH, KENYA

Example of: Bundled health microinsurance and health loan product

Description of organisation: MicroEnsure is a specialist provider of insurance to the mass market with around 60 million customers in markets across Africa, Asia and the Caribbean. It provides a range of life, health and property products via a range of distribution partners that include microfinance companies, co-operatives and mobile network operators.

MicroEnsure established itself as the Micro Insurance Agency in 2006, which was then renamed as MicroEnsure in 2008, funded by a USD 24.2million grant from the Bill and Melinda Gates Foundation. In 2013, Opportunity International divested its majority stake in MicroEnsure and the company secured investment from IFC, Omidyar Network and members of MicroEnsure's management team to provide the funding and strategic relationships necessary to continue its growth.

MicroEnsure is one of the forerunners in bringing insurance to the mass market via the mobile phone.

Description of product: As part of MicroEnsure's innovation work, a health microinsurance product called "Fearless Health" was developed and launched in Kenya in 2016. The product is no longer active, however MicroEnsure has kindly given an account of its experience to share the lessons learned.

The Fearless Health product had three benefits: a health loan bundled with a hospital cash plan that paid out a Ksh 10,000 (around USD 99) flat benefit amount for a stay in hospital for longer than two nights. On claiming, the cash was paid to the Fearless Health member and not the hospital. The third benefit was an SMS a doctor service. Fearless Health was not intended to provide comprehensive cover, which in the private sector, would have cost five times as much. In Kenya, affordable comprehensive cover is available from the government health scheme, the NHIF. Fearless Health was intended to provide complementary cover to help with OOP expenses (in combination with the benefits of the health loan and SMS a doctor service).

Experience and lessons learned: Fearless Health was launched in 2016 and lasted 8 months. In that time, 800 clients enrolled, but not everyone paid on joining. Active memberships were between 200 and 300 at its peak. The idea for the loan was that when customers needed cash for out-patient care they would use the loan. MicroEnsure believed members would rather owe MicroEnsure money than their family or friends. MicroEnsure received positive feedback that members liked the low-cost aspect of the product, which made it affordable. They also said that the combination of the loan, the insurance and the SMS-a-doctor complemented each other well. Marketing was done in a number of ways, including a road show campaign in East Nairobi (including Umoja, Buruburu). Regarding product usage, 10 claims were made in 8 months. For one or two people their claims references were not valid, but for the others, the paperwork submitted checked out and they were paid the benefits due. While feedback was always very enthusiastic, scale was not reached and the reason for this was not finding the right distribution partner.

The main lesson learned was that finding the right distribution partner and channel is key to success. Another insight gained was that those targeted need loans and are willing to repay them, and particularly liked the fact that the loan was specifically for health needs.

Source: www.microensure.com and interview with MicroEnsure, 2018.

CASE STUDY 11: ADÉFI SANTÉ, MADAGASCAR

Example of: a health mutual which has significant ownership in the MFI, the profits of which pay for health cover of members. Members pay no premium, but are required to make copayments.

Description of organization and product: ADéFI Santé is a Malagasy mutual health insurance program founded in 2009 that is linked to a large microfinance institution called ACEP Madagascar. ADéFI Santé provides premium-free insurance to 70,000 registered borrowers and family members with active loans from ACEP Madagascar. ADéFI Santé offers a progressive coverage scheme that starts with 90 percent coverage of all in-patient medical costs for members and their families in the first loan year and progressively expands to include 70 percent coverage of all outpatient costs in the second loan year. Medications that are part of the ADéFI Santé formulary are covered with a cap of 15,000 Ariary per prescription. ADéFI Santé is present in all provinces of Madagascar and is currently partnered with 110 clinical service providers.

ACEP Madagascar is one of Madagascar's oldest MFIs and is focused on lending to SMEs in urban and peri-urban settings in Madagascar. They offer 12 to 15 month loan terms at low interest rates and have 21,829 active borrowers. There are 14 ACEP Madagascar agencies distributed throughout all 6 provinces in Madagascar. ACEP Madagascar is unique in that 40 percent of the institution is owned by ADéFI Santé, meaning that 40 percent of net revenue is channelled to ADéFI Santé. ACEP Madagascar has the largest and most comprehensive mutual health insurance scheme of any of Madagascar's MFIs.

Experience to date: While the health cover is greatly appreciated by those who use it, it appears as though utilisation is lower than expected. This could indicate lack of awareness of what cover the loan members have. At the point of writing this paper, these issues are under investigation.

CASE STUDY 12: EQUITY BANK GROUP AND BRITAM, KENYA

Example of: Mobile Network Operator (MNO) distributed hospital cash microinsurance

Description of organization and products: Equitel is a mobile payment and banking platform that was launched by Equity Bank Group for its customers in 2015, that brings to the fore the convergence between mobile and banking services in Kenya. The new platform eliminates the need for mobile applications in accessing internet banking as even a simple feature phone will work in a similar manner to a sophisticated smart phone. Equitel is the first platform in Africa to offer a full banking suite without building new mobile infrastructure. Commonly known as a Mobile Virtual Network Operator, the service combines mobile and banking in a fresh, ground breaking way.

Equity Insurance Agency Limited was licensed in May 2007 by the Insurance Regulatory Authority to offer both life and non-life business. It is a fully fledged subsidiary (100 percent owned) of Equity Group. Through partnerships with reputable insurance companies in the industry, the Agency offers a full banquet of innovative insurance products and services using Bancassurance model. The Agency covers more than 1 million lives.

Britam is a diversified financial services group and offers a wide range of financial products and services in Insurance, Asset Management, Banking and Property businesses. Since 2007, Britam has established a Microinsurance business unit that provides affordable inclusive insurance products to low income population groups. In 10 years, Britam MI has become the largest microinsurance provider in Kenya and covers more than 0.5 million lives.

Equity bank Group and Britam partnered in 2017 to offer an affordable insurance to the mobile subscribers of Equitel. This product provides daily hospitalization cash benefits (cash payout for each day

spent in the hospital) to the registered subscribers. This product was expected to extend insurance coverage to over 900,000 Equitel subscribers during the initial pilot period. The insurance product operates on a “freemium” model where based on the usage of Equitel mobile services, registered subscribers are provided a free insurance coverage. Under this coverage, heavy users of mobile services can receive USD 8 for each day spent in the hospital while light users can receive USD 4 for each day (provided they were hospitalized for 3 nights or more in a row). The registered subscribers could also opt for the paid insurance coverage that provided significantly higher benefit (USD 25 for each day in hospital) in addition to the free benefits. The subscribers could opt to pay the premium on a monthly basis or on a half yearly basis. Monthly premium to cover an individual was USD 1.4, while to cover a family was USD 6.2. The product was offered entirely on the mobile platform where Equitel subscribers could register on their mobile phones using USSD platform and pay premium using mobile money. The claims process was also made easier where subscribers could directly send claim documents to Britam via the Whatsapp application.

Experience and lessons learned: The product was launched on a pilot basis in a phase-wise manner. Initially, the product was offered to around 5,000 Equity Bank staff with the intention of testing the technology platform and user experience before rolling it out to the customers. The launch helped identify a number of challenges relating to the USSD platform. One of the key challenges was the smooth operation of mobile money payments that had to be rectified before it could be rolled out to the public. Thus, the staff pilot helped in ironing out a few technology related issues that improved the user experience. This provided an important lesson about the significance of a pilot launch for technology based insurance products. Starting in January 2018, the product was gradually rolled out to the broader customer base. SMS messages were sent to subscribers informing about the product and prompting them to register using their mobile phones. Within the first month, the product received more than 32,000 registrations. However, the uptake of the paid insurance product was lower than expected. Currently, the partners are exploring different ways to push the uptake including above the line marketing campaign, incentives for Equity Bank staff, outbound calling from Equity call centre and modified SMS communication.

Source: Equity Bank and Britam, 2018

CASE STUDY 13: EQUITAS BANK, INDIA

Example of: Direct investment into health of members

Description of organization and health intervention: Equitas is an MFI operating in India, focused on individuals and MSEs underserved by formal financing channels. One of the main reasons for over indebtedness amongst the low-income in India is the need to find money for unforeseen health expenses. In response, Equitas has been conducting health screening camps since November 2008. As at 2017, Equitas’ health services have cumulatively benefited over 4.5 million clients.

Experience to date: Health services offered at these camps include:

1. **Primary Healthcare:** the primary healthcare medical camps were offered to all clients in the low-income community, distributed 91,502 spectacles, and performed 27,950 cataract operations for free. Equitas also arranged for evening clinics for doctor consultations.
2. **Secondary Healthcare:** Equitas has an agreement with a network of hospitals to provide treatment for serious illnesses at a discount. 29,177 people have benefitted from these discounts.
3. **Health helpline:** Eligible members can call this dedicated line for serious illness and the operator

connects them to network hospitals

4. **Health Camps in Vehicle Finance Branches:** Equitas conduct health camps to screen truck drivers and cleaners for general health, including eye health and also educate them on HIV AIDS awareness. 45,127 beneficiaries were screened.
5. **Equitas Sugam Clinics:** Equitas ran 16 evening consultation clinics in slums and villages and either free or for a nominal consultation fee.
6. **Health Education:** Equitas conducted 5 hours of a health education module developed by Freedom from Hunger and Results, which enables women easily learn early detection methods of non-communicable diseases. This training is given to around 50,000 women each year.

Equitas allocates a monthly budget of IRS 2,000 (around USD 50) per branch to conduct its camps. A combination of process and technology innovation has helped us maintain an operational efficiency.

Source: Information provided by Equitas, 2017

CASE STUDY 14: TONIC, BANGLADESH

Example of: A mobile phone distributed health microinsurance product with the following benefits: hospital cash insurance, telemedicine, health tips and discounts at hospitals, diagnostic centres and lifestyle outlets.

Background and organisational information

Tonic is a mobile phone distributed health microinsurance product (with other bundled health benefits) operating off a bespoke digital platform. It is offered to Grameenphone customers. Established in 2015, Telenor Health aims to use technology to help make quality health and wellness information, advice and services accessible to people, particularly in emerging markets.

Grameenphone is the largest mobile operator in Bangladesh, with 60 million mobile subscribers. With Grameenphone's link to Grameen Bank, and the bank's established position in microfinance, Grameenphone can expect to benefit from the Grameen brand when extending to complementary products such as insurance and healthcare services. Launched in June 2016, Tonic is seen by Telenor as the first step to scaling mobile health services to millions of consumers across Telenor's markets and beyond.

Telenor expects Tonic to increase mobile average revenue per user (ARPU) and improve loyalty.

Bangladesh: The reality and challenges of health cover

Total spend on healthcare in Bangladesh is only USD 88 per capita, far below the South Asia average of USD 234. Total health expenditure is 2.8 percent of GDP in Bangladesh while low- and middle income countries spend on average 6 percent of their GDP on healthcare. Likewise, access metrics are well below the levels of similar countries. The mortality rate (176 per 100,000 live births) also needs to fall sharply if Bangladesh is to meet the SDG 3 target. Poor access to health information and low patient empowerment create cost inefficiencies and a high burden of diseases (GSMA Intelligence, 2017).

Telenor Health's mobile solution: Tonic

Tonic is described by Telenor Health as a health and wellness services platform that provides a range of digital health services. In contrast to healthcare, banking, finance and insurance, mobile access has

greater coverage and penetration in Bangladesh with more than half of the population using mobile services. Telenor Health therefore identified that mobile connectivity could potentially drive access to healthcare services and greater delivery of healthcare information.

The three Tonic options for Grameenphone subscribers

Benefits provided through the different Tonic packages include combinations of the following components – the level of cover and access to benefits depends on the package selected as can be seen in Table 2:

Consultations and advice

- Personalised health content (SMS, app, web) including advice on preventative health
- Telemedicine, namely mobile-based consultations with doctors (calls and in-app chat) – called “Tonic Doctor”

Healthcare services

- Nationwide appointment booking service
- Discounts on health tests and specialist care, called “Tonic Discount”, through Tonic’s country-wide network of partners providing discounts on services (health checks, labs, medications, procedures)

Financial assistance

- Hospital cash insurance called “Tonic Cash”

There are three different Tonic packages on offer to Grameenphone mobile customers as detailed in Table 2.

Table 2. Premium and Benefit options for Tonic

Premium and Benefits	1. Tonic Free	2. Tonic Confidence	3. Tonic Protection
Premium	Basic version of Tonic – free aside from the cost of calls to Tonic doctor	BDT 126 / USD 1.52 per person per month	BDT 296 / USD 3.54 per person per month
Tonic Hospital Cash Benefit	✓ BDT 1,000 can be claimed up to 4 times per year, so a total of BDT 4,000	✓ BDT 10,000 Can be claimed up to 10 times every year, so a total of BDT 1,00,000	✓ BDT 25,000 can be claimed up to 10 times a year, so a total of BDT 250,000
Appointment Booking	✗	✓ 2000+ doctors (dial the app, web site or 789 to get the facility of bookings from 2000+ specialist doctors across the country.)	✓ 2000+ doctors (dial the app, web site or 789 to get the facility of bookings from 2000+ specialist doctors across the country.)
Renowned doctors 30+ nationwide	✗	✗	✓ Health advice, reserved appointment and choice of

			appointments at a special time from more than 30 reputed doctors
Doctor chat		 Once a month talk to doctors about any of your health related problems, anytime, anywhere, from anywhere	 Twice a month talk to doctors about any of your health problems, twice a month, anytime from anywhere
Executional Health Check-up			 Discounts up to 50 percent on partner outlet in the Exclusive Health Check-up designed by the International Standard Medical Team
Tonic doctor	 BDT 5 rupees per minute	 30 minutes free talk to doctors for any of your needs, anywhere in 30 minutes for free anytime from anywhere	 90 minutes free talk to doctors for any of your needs, anytime from anywhere in the free 90 minutes of the day
Tonic Discount	 Up to 50 percent discount in more than 200 hospitals, diagnostic and lifestyle outlets nationwide	 Up to 50 percent discount in more than 200 hospitals, diagnostic and lifestyle outlets nationwide	 Up to 50 percent discount in more than 200 hospitals, diagnostic and lifestyle outlets nationwide
Health channel		 Get tips from 2 channels, Facebook, App, Website or SMS according to your preferences on what you need to be good	 Get tips from 5 channels, Facebook, app, website, or SMS according to your preferences about what you need to be good
SMS Health Tips		 Get the maximum of 4 tips a week on what you need to be good, from 2 channels of your choice, through Facebook, app, website or SMS	 Get the maximum of 10 tips a week on what you need to be good, from 5 channels of your choice, through Facebook, app, website or SMS

Experience

Tonic was launched in June 2016. By September 2016, Tonic had 1 million members. 2 million members were reached by December 2016. As at March 2017, there were 2.85 million members.

By June 2017, according to a report by GSMA:

- Health tips and articles has reached 2 to 3 million people per month through mobile channels
- More than 80,000 phone-based primary care consultations had been conducted through Tonic Doctor
- 25,000 discounts had been used to save money on medical services, and
- Over 350 claims had been settled and paid through Tonic Cash.

Source: GSMA Intelligence (June 2017), conversations with Tonic and <https://mytonic.com> – information as at December 2018

CASE STUDY 15: DISCOVERY HEALTH'S VITALITY SCHEME, ORIGINATING IN SOUTH AFRICA

Example of: a reward program to incentivise healthier behaviour

An example of a reward-based scheme bundled with insurance, savings and investment services is the Vitality scheme developed by Discovery Health in South Africa over 25 years ago. Today the Vitality Programme is the world's longest-standing incentive based health promotion programme, with nearly 4 million members worldwide. As suggested by Morgan (2017), Vitality-like schemes could be adapted to the low-income market, with the potential to drive both scale and improve health outcomes.

Description of related organisations: Discovery Limited is a South African-founded services organisation that operates in the health insurance, protection, short-term insurance, savings and investments, and corporate wellness. Founded in 1992, Discovery was guided by its mission to make people healthier and to enhance and protect their lives. Discovery launched Vitality over 25 years ago as a pioneering insurance business model that actively promotes health. The Vitality Programme is now referred to by Discovery and others in the group as "Vitality Shared-Value Insurance". Their "Global Vitality Network" is an alliance of leading insurance organisations around the globe using Vitality to underpin their product offerings. Vitality, in various forms, is bundled now not only with health insurance, but also life insurance, property and casualty and savings and investment products. As at December 2017, eight leading FSPs (mostly insurers) were part of the Global Vitality Network offering Vitality alongside financial services in 14 markets.

Description of the Vitality model: The model brings together behavioural economics, micro-incentives and gamification with insurance and other financial services. Vitality provides people with incentives to improve their health through gym memberships, discounts on healthy foods, and other awards based on the achievement of personal health goals, and then rewards members dynamically through lowered annual premiums, free travel, and other perks. The Vitality scheme works as follows: if you go to one of the participating gyms, then the more frequently you go, the more points you earn. Points are also rewarded for other health seeking activities. The number of points you have determines your Vitality status. As your status improves, you receive increasing discounts on your health premiums and access to other benefits, which are beneficial to your physical and mental health, e.g. discounts on gym clothing, discounts to health spas and movie tickets etc. These discounts are the reward for the healthy behaviour: e.g. taking exercise.

Experience and lessons learned: According to Jais et al. (2017), there is evidence that the Vitality scheme can change members' behaviours and possibly makes them healthier. The study, also referenced in an article for the Harvard Business Review, showed that Vitality members generate up to 30

percent lower hospitalization costs.

Discovery claims that the consequence of Vitality's success is a structural transformation of insurance. In the shared value model, it is believed that additional economic value is unlocked, creating benefits for the member (more years of healthy life), the insurer (reduced claims over time), and society (healthier, more productive citizens).

There is evidence that by rewarding people, their behaviour can be changed. Vitality's success across the globe shows that reward-based programmes fit well with insurance.

Sources: Jais et al. (2017), Morgan (2017) and information from the following websites, as at December 2017:

- <https://www.discovery.co.za/vitality/join-today;>
- [https://www.vitality.co.uk/careers/our-history/;](https://www.vitality.co.uk/careers/our-history/)
- [https://triggerise.org/;](https://triggerise.org/)
- <http://sharedvalueinsurance.com>

SOCIAL FINANCE

The ILO's Social Finance Programme works with the financial sector to enable it to contribute to the ILO's Decent Work Agenda. In this context, we engage with banks, microfinance institutions, credit unions, insurers, investors and others to test new financial products approaches and processes.



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