

VALUE-ADDED SERVICES IN HEALTH MICROINSURANCE

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In the Indian state of Andhra Pradesh, the Aarogyasri/HMRI call centre handles 25,000 calls a day, providing clinical advice to a population of 85 million. This is perhaps the most dramatic example of the growing number of health microinsurance (HMI) schemes enhancing their client value proposition with value-added services (VAS).

Low-income families frequently mention health risks as the prime risk they face and against which protection is desperately needed. These same families nevertheless show a limited appetite for a basic HMI product which for a generally affordable price (about US\$10 per family per year in India) offers protection against the potentially devastating economic effects of a hospital stay. The lack of tangibility, the infrequency of hospitalization, and the willingness of family and friends to assist at such a time of crisis make hospitalization HMI a low-value proposition for low-income families. Thus, demand, and therefore the market potential, for voluntary HMI has, in the main, proved disappointing for many HMI practitioners.

By contrast low-income families clamour for assistance with more immediate health expenditure, most notably that associated with outpatient (OP) care. Contrary to earlier research, recent findings have shown that the constant "dripping tap" of OP expenses (consultations and medicines) for acute, often infectious, diseases and chronic conditions drives three times as many families into poverty as do inpatient (IP) expenses. Unfortunately comprehensive benefits for OP care would be unaffordable for low-income families, where the premiums would likely be two to three times higher (US\$ 20-30 per family per year in India) than the premium for just IP coverage.

A number of HMI practitioners, primarily in the Indian subcontinent, have begun to experiment with offering VAS to enhance the appeal of a basic HMI product. VAS are of interest to HMI providers because of their significant potential to improve both the business viability of HMI and its client value proposition. For clients, VAS provide a tangible, more immediate value (compared with just IP insurance) and will, in theory, keep them healthier, hence more productive. VAS should generate additional business value by reducing both policy acquisition and claims costs. By promoting higher renewals, VAS could play a role in managing adverse selection, by reducing the propensity of clients to selectively enrol when they expect to use the benefits provided, and then dis-enrol afterwards to avoid on-going premiums. If VAS promote earlier diagnosis and treatment, they could also reduce the frequency and intensity of IP care, hence reducing claims costs for the IP HMI schemes with which they are bundled.

This briefing note¹ presents results from a review of 13 HMI schemes with VAS and also presents insights from seven programmes that are not currently linked to HMI, but could become VAS in the future.

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¹ This brief is excerpted from the Microinsurance Paper no. 19, which includes the relevant citations and details on methodology and the cases reviewed. The paper is available at www.ilo.org/microinsurance. John Pott is an independent consultant and Jeanna Holtz is part of the ILO's Microinsurance Innovation Facility.

TYPE OF VAS

VAS are defined as services that are bundled with existing HMI schemes to provide better value to clients and improve the business viability of HMI schemes. VAS are available to members of an HMI scheme either at the time of enrolment (for example, an initial check-up for the enrollee) or thereafter during the coverage period (for example, discounts for visits to doctors or on purchases at pharmacies).

Table 1 lists the HMI VAS encountered by the study as well as those that could be linked as VAS in the future.

Of these VAS, the Dial-a-Doctor services have achieved the greatest scale and proliferation, possibly because

they appear to be most highly valued by clients. Taking advantage of the now widespread use of mobile phones, a Dial-a-Doctor service provides “virtual” consultations for low-income households, especially important in remote areas. Larger operators function as a call centre, with a team of nurses and doctors placed in a central location and accessible through the call centre. The more sophisticated programmes make use of clinical diagnosis algorithms, which enable incoming calls to be dealt with by nurses at the call centre. The nurses make a diagnosis and provide clinical advice on relatively simple cases (for example, treatment of conditions with over the counter (OTC) medicines).

Table 1 Types of VAS (present and future)

VAS category	VAS intervention	Description
PREVENTATIVE	Health education	➤ Client education to prevent illness and promote better health (hygiene, nutrition, etc.)
	Health camp	➤ Most common of preventative VAS; can include education, consultation and prescription of medicines
	Health check-ups	➤ Clients are screened for health risks or disease (e.g. hypertension)
THERAPEUTIC: CONSULTATIONS	In-person consultation	➤ A visit that involves direct physical examination of the patient and real-time exchange between patient and healthcare provider. Generally limited in scope or number of visits to contain costs; designed to reduce OOP expenditure and improve access to primary care.
	Remote Consultation: Dial-a-Doctor	➤ Telephonic contact with a healthcare provider (nurse or doctor). Typically positioned as a convenient, low-cost way to provide access to basic diagnosis and medical advice. Can lead to referral for an in-person consultation if warranted. Greatest scale and proliferation of VAS to date.
	Remote consultation: assistant using remote doctor and technology-enabled diagnostics*	➤ Technology supported transmission of basic diagnostic information (e.g. blood pressure, ECG, pulse) by a medically trained health assistant to a doctor who provides a remote diagnosis and recommended treatment to the patient.
THERAPEUTIC: ACCESS TO LOW-COST SUPPLIES AND SERVICES	Low-cost medicines	➤ Provision of quality medicines to clients at owned or contracted pharmacies at a discounted or below market cost; designed to reduce OOP expenditure and improve access to medicines
	Low-cost clinics*	➤ Provision of low cost consultations, low cost medicines and low diagnostics, with doctors employed by the clinic
	Low-cost diagnostics	➤ Provision of quality diagnostics to clients at owned or contracted pharmacies at a discounted or below market cost; designed to reduce OOP expenditure and improve access to primary care
	Emergency medical assistance	➤ Employs GPS technology and incoming call dispatch centre to facilitate appropriate, quick-response access to care in case of medical emergency. Includes ambulance transport of injured or seriously ill patients to an appropriate hospital.

* Potential VAS services to be linked to HMI schemes.



When cases are more complicated (for example, when there is a need for prescription drugs), nurses refer the case to a call centre doctor.

Other VAS schemes offer a limited number of free OP visits per year. Technology-assisted diagnostics transmitted to a doctor working from a remote location, when linked to an HMI scheme, offer significant potential as VAS for the future. Yet other schemes offer access to either discounted/low-cost medicines or, for the future, access to low-cost chains of clinics. Such VAS seek to have a favourable impact on claims, with the prospect of patients saving out-of-pocket (OOP) expenses, seeking health care earlier rather than later, and consequently lessening the chance of an expensive IP claim to the insurer. Indeed, there is some evidence that access, even if limited, to OP services lowers IP claims. Data on discounted OP VAS by Swayam Shikshan Prayog (SSP) in India show that member proximity to discounted OP clinics may be associated with lower hospitalization rates, leading to lower overall costs for the insurer. Villages with a clinic have a hospitalization claim rate about 50 per cent lower than villages where a clinic is more than 2 km away.

Some HMI practitioners seek to add preventative VAS, examples being health talks and health camps, where

the emphasis is on better health habits and health-seeking behaviour through health education. Often the draw for health camps is a free consultation. VAS which encourage better health habits and behaviour have substantial prospects of reducing overall claims costs and are reasonably inexpensive to provide; however, they are less popular with clients because of their lack of immediate and tangible impact on OOP expenses.

CLIENT AND BUSINESS VALUE OF VAS

Presently, there are limited data to enable a robust quantification of the possible benefits of VAS to clients and to HMI practitioners, and even the scale at which various VAS operate. In the Indian subcontinent, a Dial-a-Doctor service seems presently to be the most viable of VAS. For example, a rural household benefits when it can resolve a health-care need with a remote (mobile phone) consultation, instead of having to give up a day's work and incur transportation costs to obtain a more costly consultation in person with a doctor in town.

There is no direct evidence of a reduction in claims, which should yield business value to the insurer. However, the Aarogya Raksha Yojana (ARY) and Swayam Shikshan Prayog schemes combined with research on the

Box 1 The economics of Dial-a-Doctor

The cost of Dial-a-Doctor services, based on data from these schemes, is estimated to be INR 50 (US\$ 1.00) per call. For HMI scheme members using the service for 40 per cent of their episodes of illness, the cost to the HMI scheme of providing such a service is INR 35 (about US\$ 0.65) per member per year.

The most significant, and encouraging, finding common to almost all these Dial-a-Doctor operations, whether large or small, government-supported or independent, is that around 70 per cent of incoming calls for medical assistance are resolved during the call – most frequently with advice that the patient use OTC medicines. Calls which do not require referral to a health-care provider save the patient money (lower or no travel costs, less disruption of work). The remaining 30 per cent of calls require referral for an in-person consultation with a doctor. The authors estimate that Dial-a-Doctor services can generate savings in consultation costs for clients of up to US\$ 3 per family per year in urban areas. In rural areas, savings in transport costs and lost earnings, in addition to savings in consultation costs, can amount to as much as US\$ 10 per family.



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Government of India's Rashtriya Swasthya Bima Yojana (RSBY) scheme, suggest that ease of access to OP services should reduce IP claims significantly. It is reasonable to assume that the same should be true of Dial-a-Doctor services given the ease of access to them, especially since experience has shown that 70 per cent of concerns are resolved during the call, and no referral for a prescription or physical visit is required (see Box 1 for cost-benefit details).

Similarly, reducing clients' high OOP expenditure for medicines through discounts negotiated with a local pharmacy should be attractive to many clients. This should be especially applicable outside the Indian subcontinent, where medicine prices are higher, and higher retail pharmacy margins provide scope for significant negotiation. Such a VAS benefit can be achieved at virtually no ongoing cost to the HMI scheme, and should yield business value through increased loyalty and the prospect of greater market penetration, therefore reducing the cost to the HMI scheme to acquire new clients. Again whilst intuitively reasonable, limited data are available to support such implicit business benefits to the HMI scheme. However, as an example, during focus group discussions in Tanzania, microfinance clients stated that discounts of 30 per cent would certainly attract them to an HMI scheme. At the same time it was found that

pharmacies, with retail margins of typically 40 to 60 per cent, would be prepared to grant a discount of up to 30 per cent on their normal retail prices to members of a fair sized HMI scheme, if the HMI scheme members were directed exclusively to them, rather than to their competitors. Discounts on medicines are especially important, since medicines in many countries comprise the largest component of burdensome OP expenditures (which, as mentioned above, are the prime cause of low-income families falling back into poverty).

VAS that feature preventative health services are more difficult to evaluate. On the one hand, there is wide evidence that high levels of communicable diseases can be curbed by simple interventions, suggesting substantial benefits for clients. Hence, it might be reasonable to assume that there would be business value to the HMI scheme of health camps or other hybrid approaches that combine some education with diagnosis and providing simple solutions on-site. On the other hand, client enthusiasm for preventative health education is lukewarm and, as shown by recent research by VimoSEWA in India, increased knowledge and individual behavioural change do not necessarily translate into improved health outcomes, at least in the short term, for common illnesses (see Box 2).

Box 2 VimoSEWA's health education campaign

VimoSEWA operates a health program that includes community-based group health education, doorstep primary health-care service by community health workers (arogya sevikas), and facilitating access to OP services, including referral, when appropriate, to government healthcare services.

A research project with support from the ILO's Microinsurance Innovation Facility evaluated the impact of providing targeted health education on commonly claimed-for conditions.

The education intervention was implemented by a randomly chosen group of health workers and evaluated through a cluster randomized trial. Through concurrent qualitative investigation, VimoSEWA learned that hospitalization for common illnesses resulted only after repeated OP care interventions.

The VAS improved knowledge and preventative health behaviour amongst urban (but not rural) participants, but did not decrease hospitalization for diarrhoea or fever. With the added understanding that hospitalization was sought only after other options failed, the findings indicate that improved OP care and structural interventions in water and sanitation are paramount in decreasing claims for hospital stays for common illnesses.



A tailor-made "snakes and ladders" participatory game on the prevention of diarrhoea and malaria used by VimoSEWA

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EMERGING LESSONS

VAS can be further improved. Several key lessons emerged and should be of interest to HMI practitioners implementing VAS.

First, HMIs providing VAS should promote each service and educate clients about them. Several interventions have faltered on account of clients' lack of understanding and awareness of the new services. As a result, some VAS have been underused and under-appreciated.

Second, VAS, when outsourced to third parties (for example, health-care providers delivering OP services), require the HMI schemes that support the VAS to have in-house medical expertise.

Third, phasing of VAS is important. If VAS are launched at the same time as HMI, their success may be jeopardized because of lack of focus. It is important to get

the core insurance product to some reasonable level of scale and stability before embarking on VAS initiatives; or, as has been suggested, begin by introducing the VAS, and then add the insurance component.

Fourth, most VAS innovators have focused on one intervention, but others have tried two or more at the same time. Whilst this multi-intervention approach can enable useful feedback from clients on the relative merits of the VAS, the risk is that resources are not sufficiently focused to make any one of the interventions effective enough to be appropriately appreciated by clients and for full business value to be realized.

Finally, it is the government-sponsored schemes that have taken the lead in driving scale of VAS. For the smaller, private-sector HMI schemes, not surprisingly, the scale of VAS is a function of their ease to implement.

Clearly more VAS interventions need to be launched in the next two years, in the Indian subcontinent but in particular in other developing countries. At the same time a research programme encapsulating these emerging initiatives needs to be pursued so that many of the gaps in knowledge can be filled by solid empirical findings and data. In the interim, broad measures often used as a proxy for assessing the effectiveness of health-care financing or delivery mechanisms, such as child and maternal mortality, can provide first indicators of impact.

VAS in HMI can provide more tangible value for clients and promote better risk management decisions and health practices. If improved health practices lead to better health, this could result in a more favourable business case for IP HMI through higher take up, renewals and lower IP claims. For this reason, VAS promise to be part of a multifaceted solution under which HMI can become a more valued and viable mechanism to protect the health (and wealth) of the poor.

Housed at the International Labour Organization's Social Finance Programme, the **Microinsurance Innovation Facility** seeks to increase the availability of quality insurance for the developing world's low income families to help them guard against risk and overcome poverty. The Facility was launched in 2008 with generous support from the [Bill & Melinda Gates Foundation](#) to learn and promote how to extend better insurance to the working poor. Additional funding has gratefully been received from [several donors](#), including the [Z Zurich Foundation](#) and [AusAID](#). See more at www.ilo.org/microinsurance



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