Strengthening Micro Health
Insurance Units for the Poor in India

What we have learned, and what next?

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The context (the fundamental double problem)

- Govt spends less than 1% of GDP for health – deficient implementation of health services
- Commercial health insurers target mainly
  - ✓ high-net-worth urban people
  - ✓ very selective risks

Consequently:

- 97% of people in India must pay out-of-pocket at point-of-service most of their healthcare costs.
- OOPS represent some 75% of total healthcare costs (WHO)

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The key questions for interventions:

- What do the clients need and want?
- How much will the clients pay?
- What can one reasonably expect to deliver for this sum?

And:

- What role can the Dutch Platform play?

What do people prioritize?

CHAT:

"Choosing Healthplans
All Together"

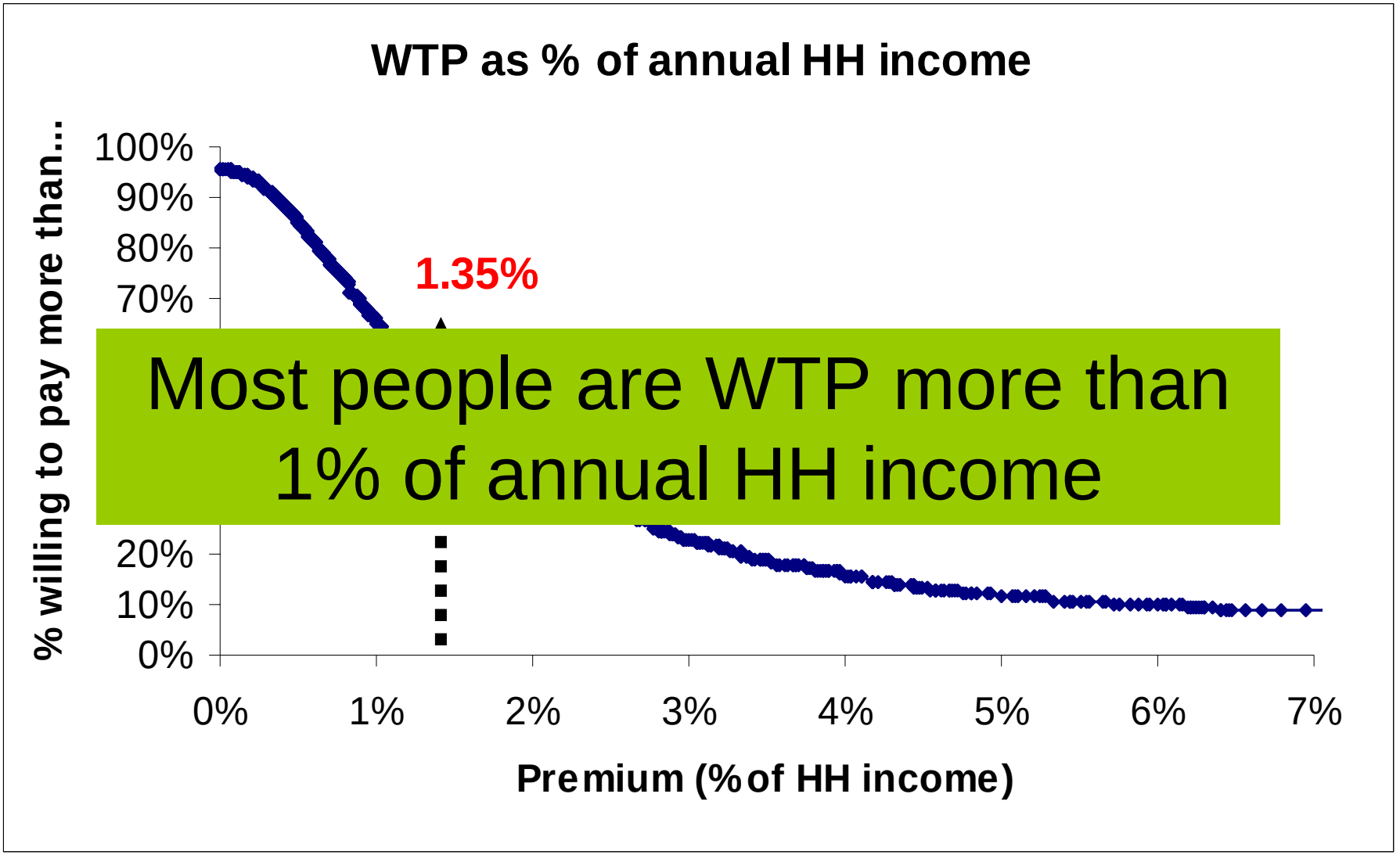
(the video from India)

Poor people have clear priorities on what they would pay for

- People want coverage for expensive care, not only rare care
- Drugs are the most expensive item
- People prefer broad coverage at basic level over narrow coverage at high level
- The poor want to participate in the design of their health insurance benefit package (and can make judicious choices)

How much are people willing to pay for health insurance?

Are the poor willing to pay for HI?



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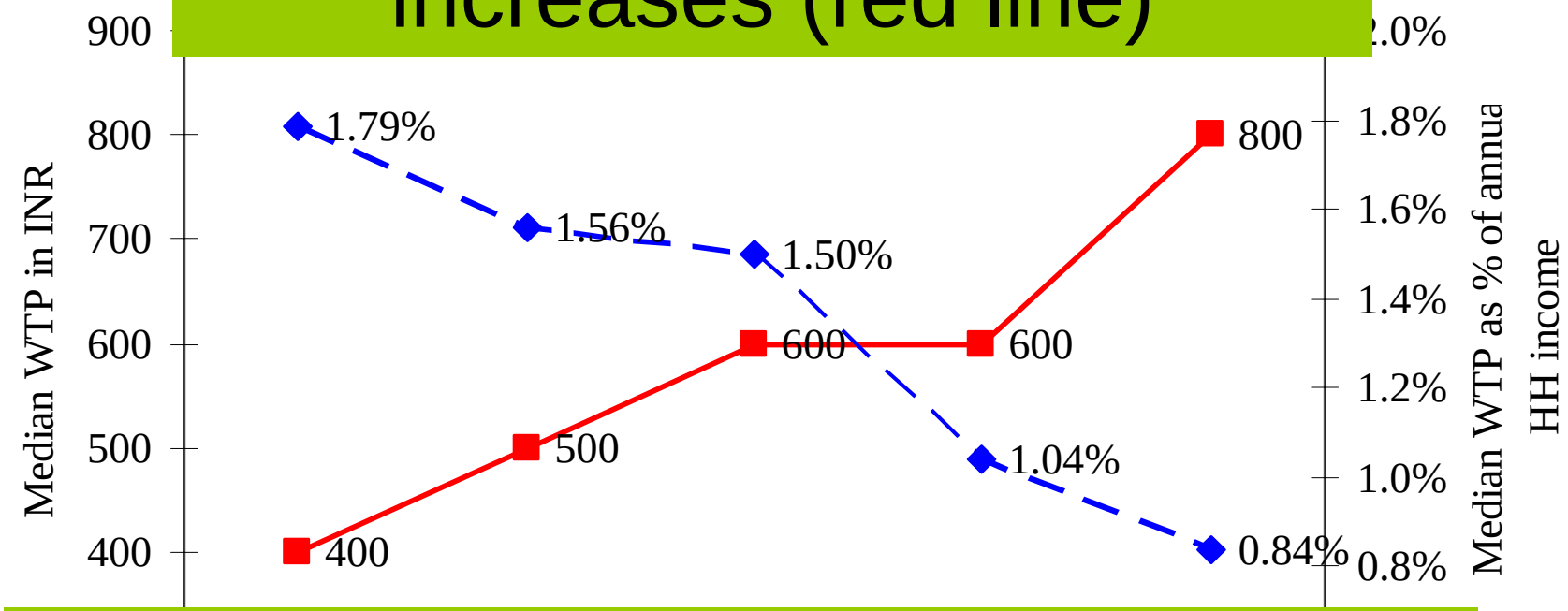
The poor & WTP

WTP increases when income increases (red line)



The poorest agree to pay a higher percentage of HH income (blue line)

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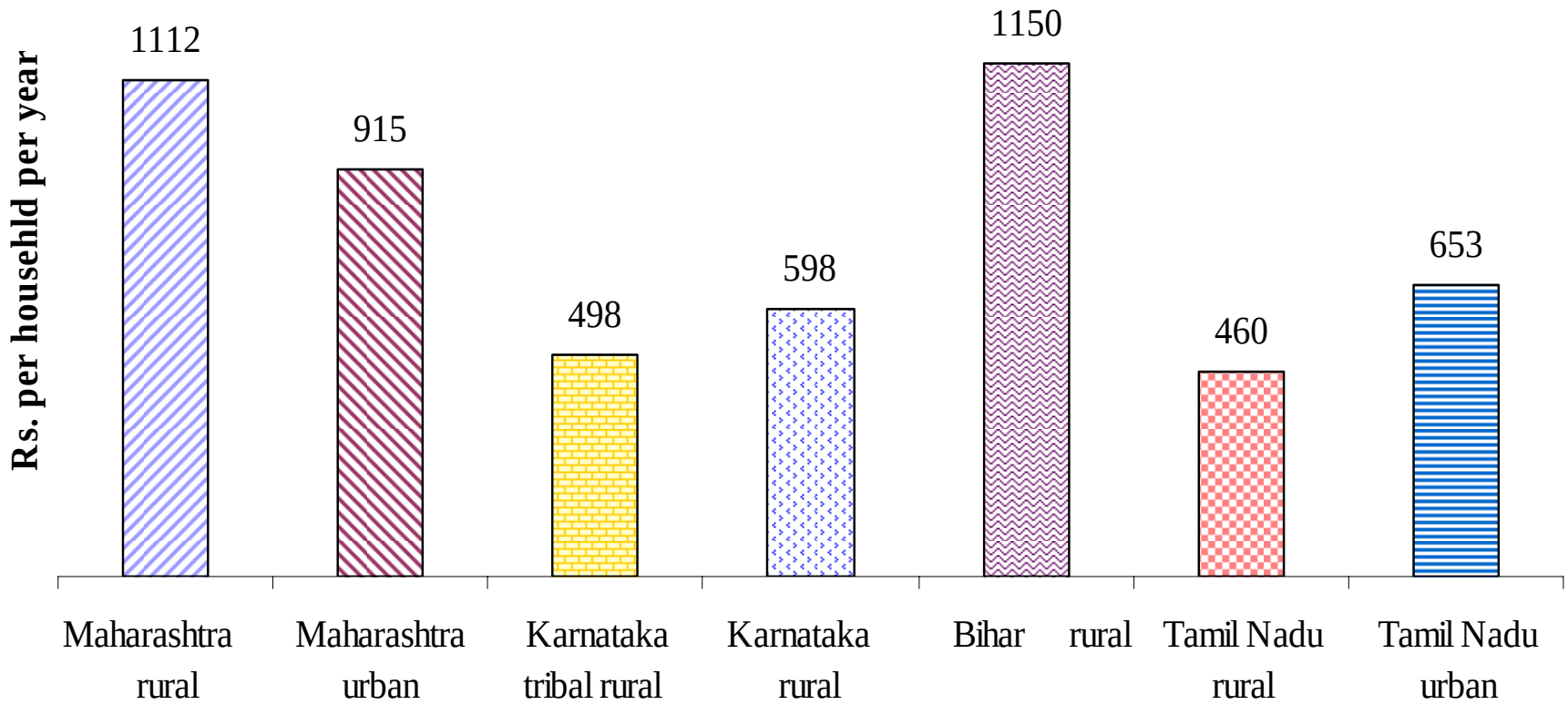
But WTP differs across locations

The average WTP must be checked locally and periodically



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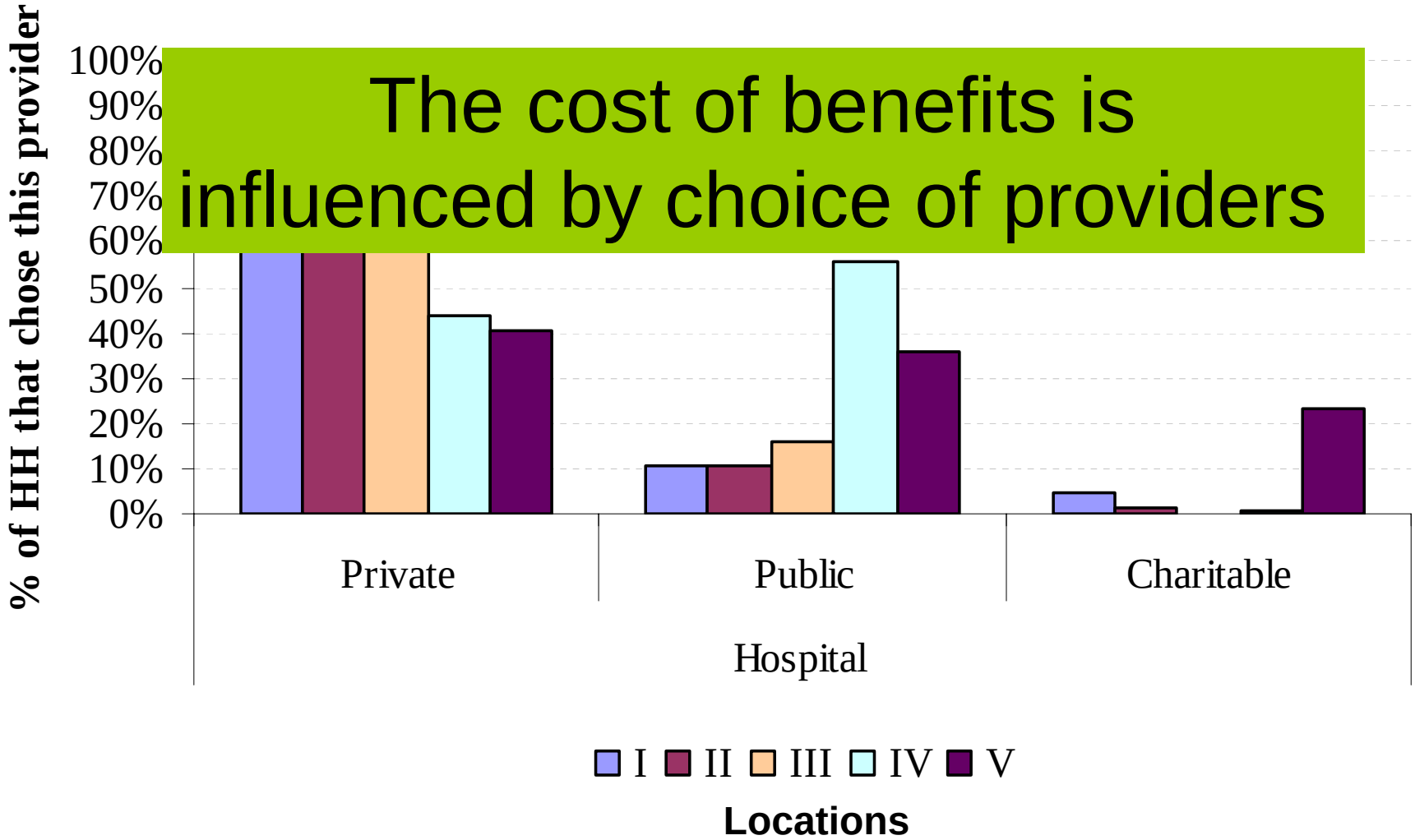
What about the supply side?

- Private providers deliver most healthcare to the poor in India
- Private does not always mean better
- Provision is a function of solvent demand, not of needs of the clients
- Insurance can enhance solvent demand, but cannot be responsible for supply

The choice of providers differs across locations



The cost of benefits is influenced by choice of providers

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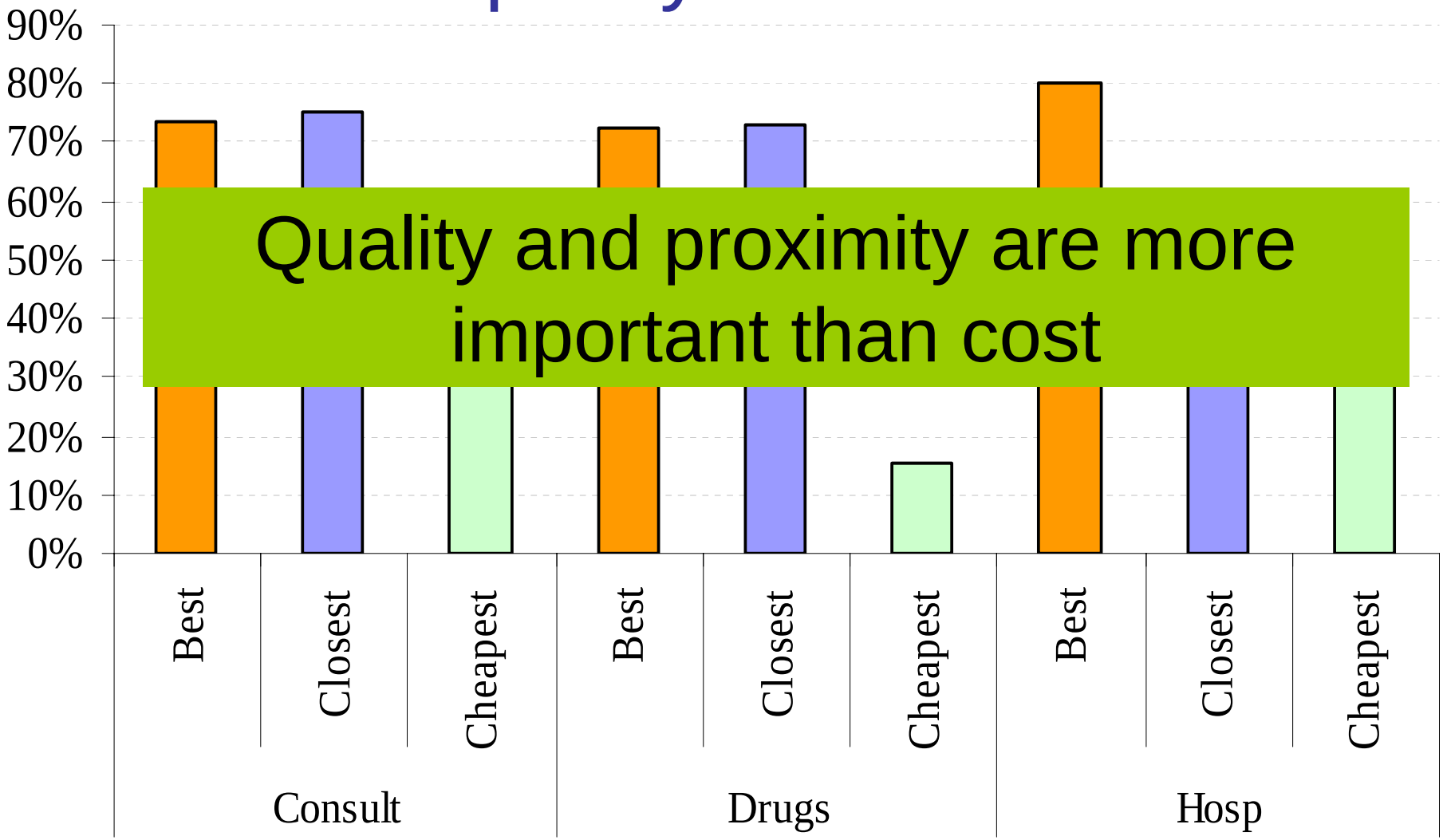
Ownership less important than quality of care



Quality and proximity are more important than cost

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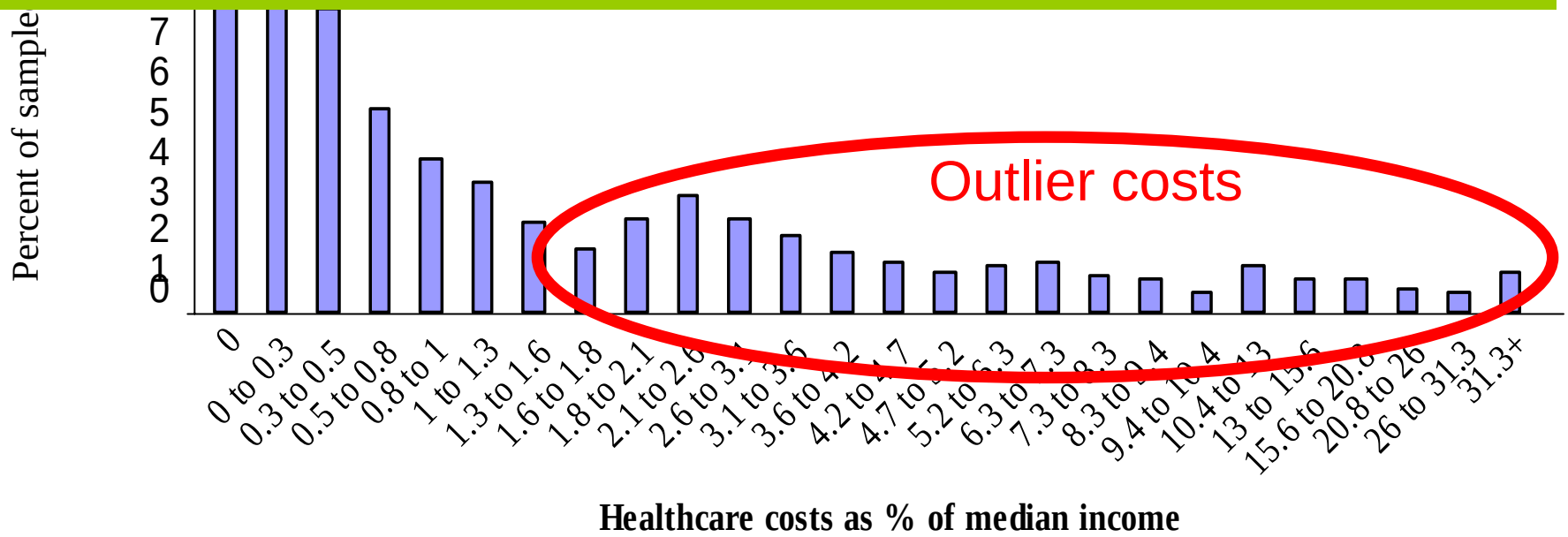
What can one deliver?

- The bigger the insured group, the lower the cost of risk (lower fluctuations & lower risk of adverse selection)
- The broader the range of risks, the more cross-subsidization across heads-of-damage (& less moral hazard)
- Procurement can reduce extreme mark-ups of prices

Broad-based WTP can cover most illness cases

With WTP of 1.35% of median income
it is possible to cover more than half the HH with illness. The outliers can be covered only through reinsurance / subsidy



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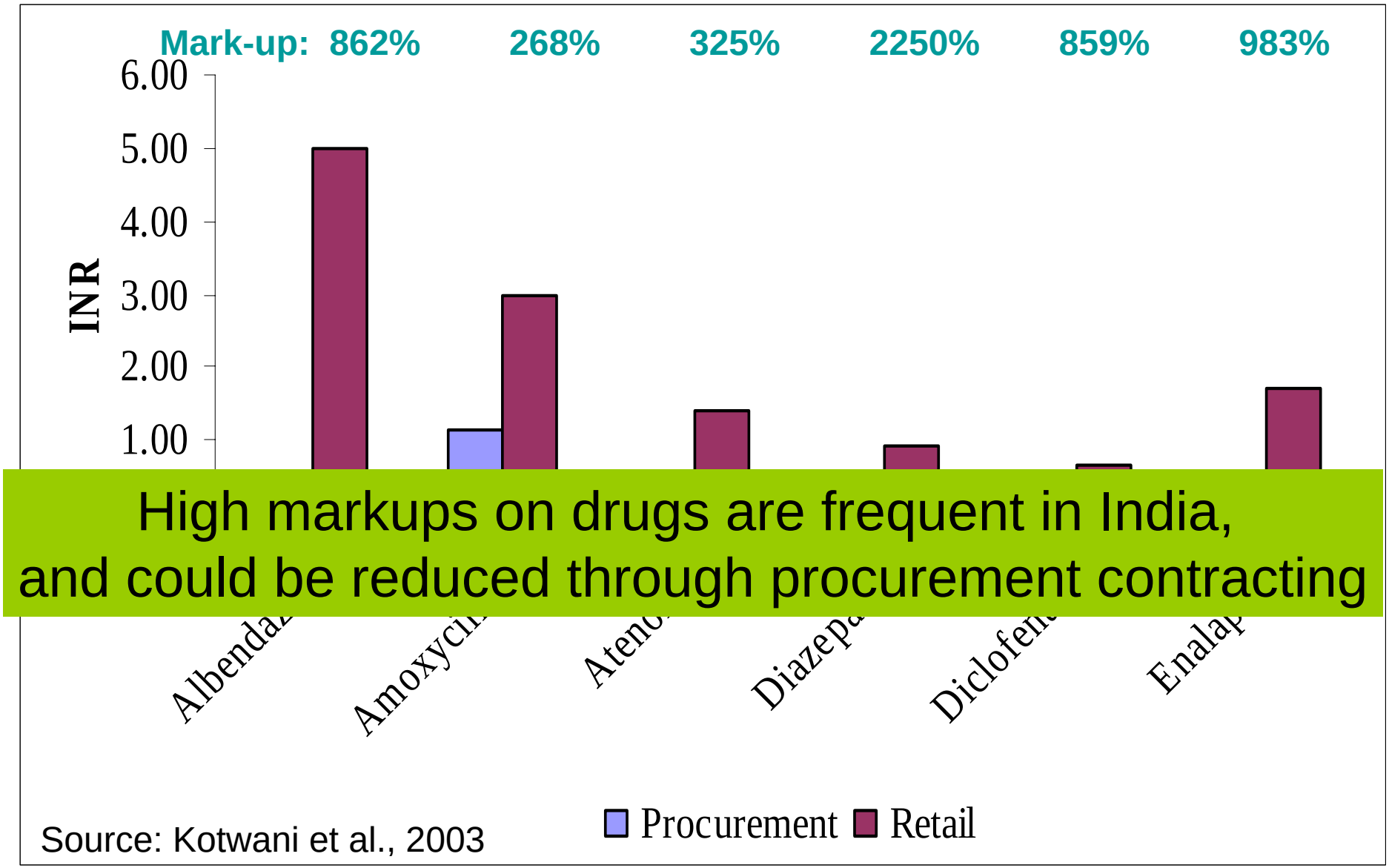
The high cost of care is shrinkable



High markups on drugs are frequent in India,
and could be reduced through procurement contracting

Source: Kotwani et al., 2003

Lessons

- MIUs are best suited to deal with the heterogeneity of needs, demand & supply
- MIUs are best suited to maximize the opportunities inherent in social capital
- MIUs are thus desirable interlocutors, not merely the ‘lesser evil’
- Compared to top-down alternatives, a better, cheaper & faster way to increase access to health insurance for the poor would be to empower MIUs

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Empowerment: actionable now

- Institutional setting for capacity-building
- The technical and financial domain-knowledge will include (partial list):
  - Eliciting members' views on benefit package composition
  - The role of the 'membership officer' and collecting premiums
  - Using a Health Insurance Information System
  - Basic accounting, audit & reporting
  - Facilitation submission of claims, deciding on claims
  - Managing the democratic structure of the mutual ; etc

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Empowerment: actionable now

- The institutional setting for training does not yet exist. Therefore, we plan to establish in 2007 in Delhi the **.academy for .micro .insurance** ami
- ami will gather experts from India and abroad to develop practical course material, train persons in India, and back-stop the training activities with relevant advisory services to grassroots organizations and policy makers.

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Empowerment: medium term action

- Institutional setting to ensure the financial sustainability of MIUs requires pooling of risks and resources of many MIUs (reinsurance)
- In India, only Indian licensed insurers can cede risks to reinsurance
- Therefore, a licensed insurer must manage the pool of MIUs (unlicensed insurers).
- An Indian "Pool manager" that would agree to operate on a non-profit basis must be created.

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Empowerment: Longer-term action

- Value-added services to insured persons
  - Reducing cost of supply through contracting
  - Channeling subsidized services to broaden the benefit package, under the principle “help those who help themselves”
  - Managing subsidized preventive care of insureds (funded by donors or government)

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Summary & Conclusions

- Health insurance is not emergency intervention!
- There is a large market for low-cost HI in India & elsewhere
- This market can flourish by group affiliation and by responding to local needs-demand-supply

  (rather than “one-size-fits-all” product sold to individuals)
- MIUs need systematic capacity-building in domain-knowledge to improve their operations
- MIUs must pool through reinsurance to be sustainable
- The link to reinsurance in India requires a local “pool manager”

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Summary & Conclusions

- The conceptual framework has been fully elaborated
- We have tested that this concept is “doable”

How can this be done in reality?

- Training: (i) creation of Academy (ii) course material; (iii) training of trainers; (iv) social franchising through trainers of trainees
- Pooling: (i) creation of “pool manager” (ii) The pool manager will deliver the insurance packages that clients want to pay for; (iii) the pool manager cedes risks to reinsurance
- Reinsurance: through existing reinsurers

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Your role in the next steps?

How can the Dutch Health Insurance Forum wish support this process?

1. Help develop course material for the Academy?
2. Help fund the first batches of trainees?
3. Involvement in creating the “pool manager”?
4. Other options?

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Thank you!

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