



MILK Brief #11: Doing the Math: Health Microinsurance in Maharashtra, India¹

Studying MicroEnsure's health insurance product

Health microinsurance in developing countries aims to offer poor working populations a health financing mechanism that can reduce out-of-pocket spending on health, improve access to care, and protect them from entering an all too common spiral into deeper poverty. The MILK project partnered with the global insurance intermediary MicroEnsure to study the extent to which a health microinsurance product covering inpatient care offered value to clients in terms of reduced spending and improved access. There is strong evidence that insurance can reduce the out-of-pocket spending for families when large health crises hit (Ekman, 2004; Devadasen et al., 2007; Wagstaff, 2007),² though the extent of this protection depends on the specific product features, exactly how benefits are delivered, and the socio-economic characteristics of the target community. Our findings suggest that while the insurance coverage offered some relief, access to low-cost loans and the ability to divert current income toward the costs of the health crisis remained critical to clients' ability to finance these costs.

MicroEnsure partnered with the Solapur District Community Cooperative Bank (SDCCB) in the State of Maharashtra, India to offer an inpatient health insurance product to the Bank's borrowers. The Bank is dedicated to offering credit and savings to farmers and has an extensive coverage of 218 branches reaching 500,000 clients in the district. The health scheme, known as the Sharad Chandraji Pawar Arogya Vima Yojana,³ was in effect for one year from August 2010 to July 2011. The scheme was underwritten by United Insurance India and administered by Health India TPA (Third Party Administrator). The product covered inpatient admissions for a wide range of basic and specialist care including pre-existing conditions and a maternity benefit (both with waiting periods). As the insurance intermediary, MicroEnsure assisted with product design as well as with processes related to client enrollment, education and claims payment. SDCCB members⁴ with active loans were automatically enrolled in the scheme, and the bank paid an annual premium of USD4 on their behalf. Since its inception, the scheme covered over 200,000 members and paid 5,500 claims. While the product was designed to provide benefits on a cashless basis (rather than requiring clients to pay the up-front costs before seeking care), many hospitals insisted that clients pay out-of-pocket and submit their claims for reimbursement to the insurance company. The liquidity needs of the hospitals as well as the insurer's dispute of some claims led to hospital dissatisfaction with the cashless system. As a result, only 20 percent of claims were administered on a cashless basis with the remaining clients paying upfront and filing for reimbursement. MicroEnsure notes that delays in the claims process for both providers and clients were often related to the shortcomings of their contracted TPAs. As the first phase of the program came to a close, MicroEnsure and its implementing partners sought to explore the value that clients obtained from this inpatient health care product, as well as at the differential impact between cashless and reimbursement-based care.

Methodology

In January 2012, the MILK project initiated a Client Math study to gain insight into these issues, exploring how insured people coped with a recent health shock, compared to those who were not insured. The primary focus of our study was to understand the financial burden of the shock and the strategies used by both groups to cope with the event, including differences between those who paid with cash and those who obtained cashless

¹ This MILK Brief was prepared by Barbara Magnoni and Taara Chandani (June 2012).

² Evidence of the financial protection provided by microinsurance, as well as other components of value, is summarized in MILK's client value landscape study (Magnoni & Zimmerman, 2011).

³ Sharad Chandraji Pawar is the current Minister of Agriculture and former Chief Minister of the state of Maharashtra.

⁴ Coverage was restricted to the borrower only and did not include family members.



services. Secondly, we examined the overall experience that clients reported in the program, including their care at the hospital, awareness about the product and perception of insurance, and the extent to which their experience was influenced by the mode of claims settlement (cashless vs. reimbursement).⁵

We focused our study on a set of comparable hospitalization events that occurred in the year preceding the interviews; this offered a discrete health shock for respondents to reflect on and promised a high recall of financial information. Specifically, we chose to focus on hospitalizations due to **viral fever, malaria, typhoid or gastroenteritis**.⁶ Typically these fevers result in similar hospitalization stays of 2-3 days and account for comparable expenses related to tests and medications. We interviewed 30 insured and 30 uninsured patients from communities across the Solapur district. Five network hospitals referred uninsured patients to us who were recently admitted for one of the above fevers and paid out of pocket for their hospitalization.⁷ The most common cause of hospitalization in our sample was viral fever (representing over 35% of both groups), followed by gastroenteritis, malaria and typhoid fever. We observed that five insured respondents reported having *not* received a reimbursement from United Insurance India; since they effectively financed the hospitalization out-of-pocket and did not benefit from the coverage, we excluded them from our analysis below. Also, we excluded two outliers—an insured respondent who financed the hospitalization with a loan that was over 3 times above the average, and another who paid for temporary labor over 15 times the average—remaining with a sample of 23 insured respondents. We did not exclude any uninsured respondents from the analysis.



An insured respondent in rural Solapur

Clients vs. Non-Clients: Who were they?

The insured were more likely to be male farmers working on their own land, with slightly higher earning power and greater access to formal credit than the uninsured. In most other respects, the insured and uninsured were very similar. Given that all borrowers at SDCCB are farmers and most are men, the vast majority of insured respondents who participated in the interview (91%) were men. The uninsured were more likely than our insured group to be represented by women (37%) since they were randomly identified by the hospitals based on their recent admission. Given that the target population is rural, the household sizes were relatively large with approximately 7 people. An equal proportion of respondents in each group (87%) were homeowners.

The insured and uninsured earn their livelihood in different ways. All SDCCB members are farmers, and 91% of respondents reported deriving their main source of income from farming their own land. Only 40% of the uninsured reported generating their main livelihood from farming; the remainder reported working in the trade or services sector (30%), as public employees (10%), or in various other occupations (20%). Insured respondents earned a slightly greater share of household income (63%) compared with the uninsured (49%). The average total **monthly household income** of the insured was slightly higher than the uninsured, at USD180 vs.

| Sample | Insured (n=23) | Uninsured (n=30) |
|---------------------------------------|----------------|------------------|
| Women (%) | 9% | 37% |
| Average age | 48.8 | 40.4 |
| Own home (%) | 87% | 87% |
| Average years of education | 6 | 7.2 |
| Average HH size | 6.7 | 7.3 |
| Average respondent income (per month) | USD114 | USD75 |
| Average HH Income (per month) | USD180 | USD151 |

⁵ See MILK Brief #9: What is Client Math? for a more detailed description of the Client Math methodology.

⁶ MILK conducted another Client Math study in India that focused on these fevers (MILK Brief #12: Doing the Math in Karnataka, India (forthcoming)).

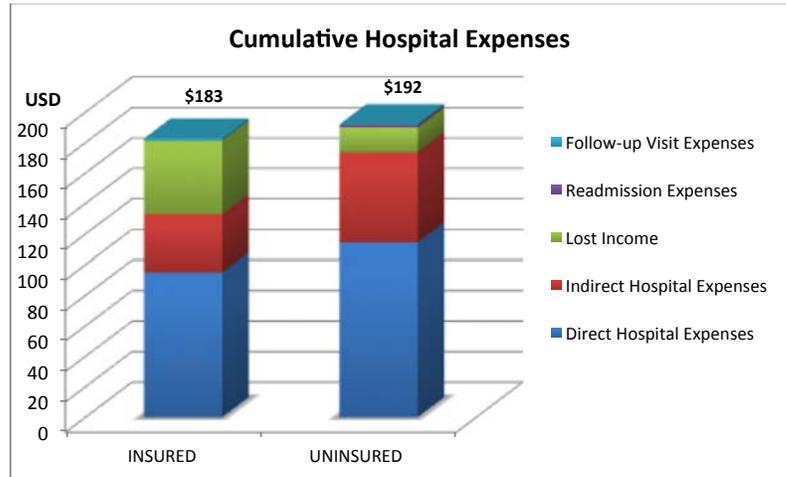
⁷ All patients offered their consent to be interviewed by MILK researchers and were given a small gift of appreciation after the interview



USD151. As members of SDCCB, the insured had easier **access to credit** than the uninsured.⁸ Nearly half the insured respondents (48%) had outstanding debt at the time of the interview, compared to only 13 percent of the uninsured. Many of the uninsured respondents (50%) claimed that they did not regularly access loans; when they did borrow, they were more likely than the insured sample to borrow from friends and family and less from formal banking institutions.

Coping with the hospitalization event

MILK's Client Math studies of health insurance analyze health care expenditures of insured and uninsured people⁹ according to four categories: *direct costs* that are incurred at the hospital, *indirect costs* that are incurred post-hospitalization, such as for pharmaceuticals or special food, *opportunity costs* or lost wages from not working, and *follow-up* or readmission expenses. With our sample in Solapur district, **direct hospital expenses**¹⁰ comprised a major driver of costs for both groups, at **USD95 for the insured and USD114 for the uninsured**. This differs substantially from the findings of our Client Math study in Karnataka, India, which



found that direct costs for the uninsured were over three times higher than the insured group as a result of the discounted rates provided by the health clinics in the insurance network.¹¹ In the case of this study, the insurance was structured differently, and many clients were reimbursed rather than offered a cashless service; as a result they could not benefit from such discounts even if offered.

Indirect expenses were comparable between the two groups, at USD38 for the insured and USD59 for the uninsured. This is expected, given that the SDCCB insurance does not cover such expenses. The majority of these costs for both groups were made for transportation and medications. **Opportunity costs**, or the loss of income from not working, contrasted more widely between both groups. Specifically, the insured reported a net loss of USD48 compared to a relatively minor loss of USD16 by the uninsured. The main driver of costs for the insured was in hiring temporary labor to work on their farms while they were too sick. Conversely, as wage earners, the uninsured were more likely to report an actual loss of income (albeit relatively small) that resulted from their hospitalization, and none of them reported *hiring* wage labor. A final set of costs that we explored was related to **medical follow-up or re-admission**. These were nominal for both groups. Despite 39% of the insured and 43% of the uninsured reporting that their doctors recommended re-admission, only 2 people in each group (9% and 7%, respectively) were actually re-admitted. Respondents reported either that they felt they "could not afford missing additional days of work" or that they felt good after the initial treatment. This is consistent with our findings in Karnataka, India, where only few clients were readmitted despite recommendations from their doctor.

In summary, **both groups had a high initial financial burden as a result of their health shock, representing over one month's household income for both groups**. The insured, of course, were

⁸ Due to Government of India sponsored subsidies, farmers can typically access loans at considerable discount; depending on the loan amount, the interest on SDCCB loans to farmers ranges from 1 to 11 percent per annum, compared with commercial retail loans at 14 percent p/a and MFI loans at 26 percent p/a.

⁹ The reader should be cautious in interpreting the graphs of costs and financing sources below, as they do not reflect *only* the direct effect of insurance purchase, but rather the combined effect of insurance purchase and 'being the sort of person who buys insurance.' Although we tried hard to ensure that the insured respondents were similar to the uninsured respondents, it may be that certain kinds of people are more likely to have insurance coverage, and this could account for some of the difference between insured and uninsured in these graphs.

¹⁰ These include all the clinical and administrative expenses that are incurred for the duration of the hospitalization: registration fees, bed charges, doctors' and nursing charges, laboratory tests and medicines.

¹¹ See MILK Brief #12: Doing the Math in Karnataka, India (forthcoming).

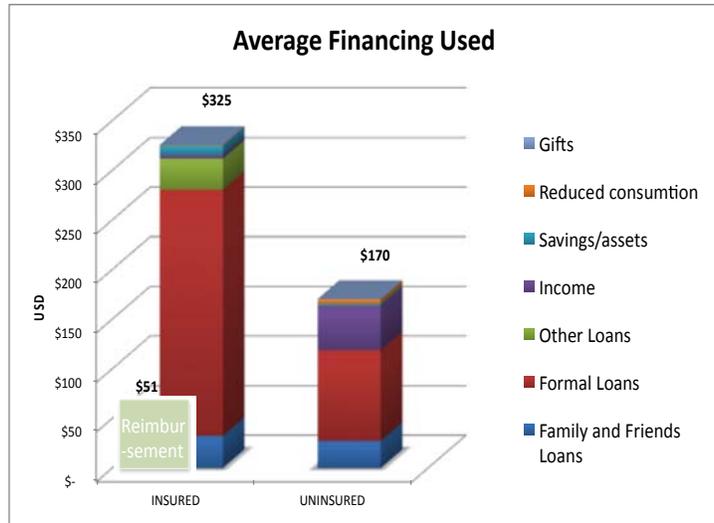


reimbursed for a part of this from the insurance company. Below we will explore the role insurance played in financing some of these costs for the insured as well as the alternative financing sources used by both groups to cover these costs.

Piecing together the financing

On average, the insured respondents who paid cash upfront¹² received USD51 in insurance reimbursements, roughly 53 percent of their direct hospitalization costs and 25 percent of their total hospitalization expenditure (See the column marked “Reimbursement” in the chart). These clients, however, waited an average of 14 weeks to receive this payment and thus needed to finance the entire hospitalization expenditure in the interim period. As a result, their initial financing needs were greater than those of the uninsured.

In fact, ***the insured on average financed 1.8 times their total hospitalization expenses upfront***, suggesting that this group may have “over-borrowed.” Some of this financing might have gone toward making additional payments on the new loan. Additionally, our qualitative discussions with clients also indicate that some clients borrowed more than they needed for the hospitalization in order to finance regular household consumption, which, as mentioned above, was commonly smoothed out through loans. On average, the uninsured financed slightly less than their expenses (0.89 times), perhaps reflecting their lack of credit access and instead having to make due with disposable income available from their household to cover these costs. Access to loans from SDCCB as well as from friends and family acted as the major form of financial protection for the insured. This suggests that loans and credit access, in general, may have played a greater role in relieving the financial burden of the hospitalization than the insurance itself.



For both groups, formal loans served as the main funding source, particularly for the insured, who used these loans to cover 76% of their total financing. 50 percent of the insured sample borrowed; 22 percent from SDCCB and 17 percent from friends and family, though they borrowed a greater amount from SDCCB, averaging USD248. Only one insured respondent borrowed from a moneylender. The high level of commercial debt among the insured reflects their access to credit prior to the shock. The uninsured had more limited access to loans. Only 8 respondents (27 percent) borrowed to finance their hospitalization, and of these, only 3 (10 percent) borrowed through formal loans while the remaining 5 respondents (17 percent) borrowed from friends and family. Much like the insured, they borrowed in *greater volume* from formal sources. On average, the uninsured borrowed a total of USD120. It appears that a lack of access to credit (50% of the uninsured cited that they do not regularly access loans vs. none of the insured) explains why access to loans was more limited. Friends and family were the most common source, but not everyone believed this was ideal. Of the 5 who used this mechanism, 2 noted that friends and family loans were a necessity rather than a preference, remarking that an important factor when borrowing is to not bother friends and family. Another 3 respondents who avoided borrowing from friends and family agreed.

Perhaps because of a limited access to credit, the uninsured financed their hospitalization expenditures primarily through their ***income***. Over 60 percent of the uninsured channeled their income to finance the hospitalization compared with only 17 percent of the insured group, using USD71 worth of income compared with only USD21 by the insured, who, as discussed above, were more likely to utilize a loan. While income might often appear to be a less stressful mechanism than debt, in the case of SDCCB clients, who received loans at very low interest rates, it was not likely the case (as the productivity of their forgone income may be higher than interest on debt). For the uninsured, income also seemed to be less preferential albeit for different

¹² We exclude the clients who received cashless service from the analysis of direct costs below



reasons. Nearly half of the uninsured respondents drew on income from various members in the household to supplement theirs, and two respondents reported taking an advance from their employer. This uninsured sample appears to be more vulnerable in having to piece together various income streams from *within* their household and by taking out advances from their employers.

Another indicator of the relative vulnerability and greater stress faced by the uninsured is the reduction of basic household **consumption of food, medicine and education**. Neither group turned to this mechanism in large amounts on average (USD4 for the uninsured vs. USD1 for the insured), though 9 percent of the insured and 23 percent of the uninsured did so. The reason for the differences in responses between the insured and uninsured is uncertain, but **it appears that the higher income and greater credit access of the insured may have explained their avoiding more difficult coping mechanisms vis-à-vis the uninsured as much as the fact that they were insured.**

Perceived Value of the Insurance

Improved access to care or improved service at the provider level can be another benefit of having insurance, in particular for the poor who might face discrimination at private providers due to their low-income status. In our Client Math study in Karnataka, we found the insured perceived their treatment as equal to or better than that of their uninsured counterparts. By contrast, in this study, we find that, the **uninsured were more likely than the insured to be “extremely satisfied” with the quality of medical care received at the same clinics**. Also, 57 percent of the uninsured felt that they were treated well *because* they did not have insurance, while most of the insured (70%) believed that their insurance had no bearing on how they were treated. All of the respondents in both groups reported that their treatment was successful. While the insured did report positive sentiments about the role of insurance in protecting their income and health, their experience at the hospital points to an opportunity for MicroEnsure and the TPA to build stronger relationships with network hospitals, so that in addition to increasing attention and service quality, they will also oblige in offering cashless services for the insured.



A Doctor at a hospital that works with the MicroEnsure insurance scheme in Solapur

Over 80 percent of the insured believed that insurance had a “better” effect on their income and savings, and felt that it led to improved “peace of mind” and health status. Although in many cases the product did not provide cashless benefits as promised, this perceived value may in part reflect clients’ low expectations, given that they did not have to pay the premium out of pocket. Regardless of its cause, this perception of value in the product appears to have translated into greater demand. All insured respondents in our survey claimed that they would like to renew their insurance, and 87 percent said they would be willing to pay a premium—a majority of whom suggested they would like to pay for coverage for their spouse as well.¹³ Previous research has found that experience or familiarity with an insurance product may strengthen demand by ensuring that clients understand it and trust that it will work as promised (Giné et al., 2008; Donfouet & Makaudze, 2010).¹⁴ Interestingly, few of the uninsured had been offered insurance and those who had cited a lack of familiarity as a reason for not buying it. A lack of familiarity with insurance was not exclusive to non-clients. MicroEnsure implemented surveys in 2011 to understand customer awareness and improve training materials and found that many SDCCB clients were often not fully aware of the covered benefits or how to use the product, resulting in low utilization rates and a poor service experience. In response, MicroEnsure is testing measures

¹³ We asked respondents to select from two payment options, one that would give themselves and their spouse coverage (USD6.6 per annum), and the second that would offer individual cover at the current premium cost of USD4 per annum; 61% said they would pay for themselves and their spouse while 26% would pay for themselves alone. The majority of the uninsured (70%) also had a positive perception of insurance and 77% of that group would consider buying it in the future.

¹⁴ MILK Brief #7: A microinsurance puzzle: How do demand factors link to client value? explores this and some of the many other factors that may influence demand for microinsurance.



including familiarizing clients with products before enrolment, offering health camps and staff training on how to provide product and process information as well as establishing additional Customer Relationship Officers (CROs) who support clients. This may improve value but at a significant cost to MicroEnsure.

A Closer Look at Insured Households with Different Cash vs. Cashless Payments

Analyzing the averages of our groups reveals general trends, but can mask the nuances and subtleties of each individual story. Our analysis of average responses suggests that households with insurance were burdened by significant financing costs, even more so than our uninsured group because of the high indirect costs of their illness. However, many in this group also needed to finance the direct costs of the hospitalization because most were reimbursed by the insurance some 3-4 months after their illness. Clients who accessed cashless services incurred lower out-of-pocket payments at the hospital, though also had to finance their indirect costs. Example 1 and 2 below reveal how two clients with cashless coverage coped. They incurred lower aggregate expenses than those who paid cash upfront, but still had to resort to using savings and borrowing from a moneylender to cover their indirect costs. Examples 3 and 4, describe two clients who were reimbursed, show that they incurred high direct costs at the hospital that were only partly reimbursed; the delay in receiving this meant that they had to finance a greater outlay on their own. The respondent in Example 3 did so without strain, however, our respondent in Example 4 was strained by this delay in payment. The respondent in Example 1 below was the most vulnerable, and a cashless benefit served him well. Without the cashless benefit, it appears his household consumption would have suffered significantly. The respondents in Examples 3 and 4 however, show relative resilience in having to wait 4 weeks to be reimbursed for hospital expenses.

Example 1 illustrates the case of a poor 70 year-old farmer who lives with his wife and four children. He owns five acres of land and lives in a simple house with mud flooring. Despite his advanced age, he is an active contributor to his household finances. His gross monthly income is USD43, which is supplemented by USD86 from his wife and offspring. The respondent has an outstanding loan of USD132 from SDCCB and another, much larger, loan from an undisclosed source at USD1,522. The respondent was hospitalized in November 2010 for a viral fever. He went to a nearby private hospital that was on a pre-approved list from SDCCB. He received “cashless” service and did not incur any out-of-pocket payments at the hospital. He did pay for certain indirect costs, amounting to USD19 for his and his family members’ transport, and USD19 for managing a special diet. He was re-admitted to the hospital following this event but did not incur significant additional expenses since his insurance benefit was cashless. The respondent’s opportunity cost of illness, however, was significant, totaling about one month’s household income at USD121. He missed 25 days of work, his wife and children missed 15 days of work accompanying him to the hospital, and he hired temporary labor (costing him USD20) to tend to his farm. The respondent reported taking a 5-month loan of USD76 at 3% monthly interest from a moneylender to finance these expenses—presumably the quickest source of funds available. He did not report using other sources of financing, but presumably channeled the family’s disposable income to cover the hiring of wage labor. The bulk of the opportunity costs they faced resulted from lost time on their own land, which did not represent a cash need but instead a missed opportunity. This cost was never made up. Despite not being able to make up the cost of his missed labor, overall, the respondent was satisfied with the product and payment process. He felt that the insurance had a positive effect on his finances (especially borrowing and savings) as well as on his health status and peace of mind. Especially for the elderly, this security and improved perceived health care access can go a long way.

In the next case, **Example 2**, we are taken to the home of another male farmer, aged 43, who lives with 6 people, including his elderly parents and his children. He owns five acres of farmland, from which he earns about USD135 every month—the only reported source of income for the household. His loan with SDCCB was nearly fully paid off. He was hospitalized for gastroenteritis in June 2011 at a private hospital where he had been treated before. Like the case above, he too did not incur any out-of-pocket payments during the hospitalization, because of his cashless insurance, but had to pay roughly USD20 for transport and his special dietary needs. He missed 10 days of work that cost him roughly USD45; in addition, he hired someone for one day, at USD5, to work on his farm. The respondent financed his hospitalization by drawing on USD209 worth of his USD309 in savings. At the time of the interview, his savings had dwindled further to USD20. The respondent may not have been able to immediately access a new loan from SDCCB during his hospitalization (perhaps because he was in the hospital), and thus resorted to using savings. These savings



may have gone towards meeting basic household expenses, which he likely was smoothing through borrowing in the past, as well as covering the cost of his illness, since he was the only breadwinner in the family and their reported disposable income was low. Had he had to pay for hospital expenses above this, his household would likely have had to resort to more difficult measures. The respondent noted that without insurance he would have had to reduce household spending or access savings from a chit fund. Despite ending up worse off than before his illness because of the missed work that he had to make up by using up his assets, the respondent was satisfied with the insurance cover and believed that it significantly reduced his out-of-pocket expenses. In general, he felt positively about the role of insurance in protecting his income, his health, and in offering him peace of mind - and would be willing to pay a premium in the future.

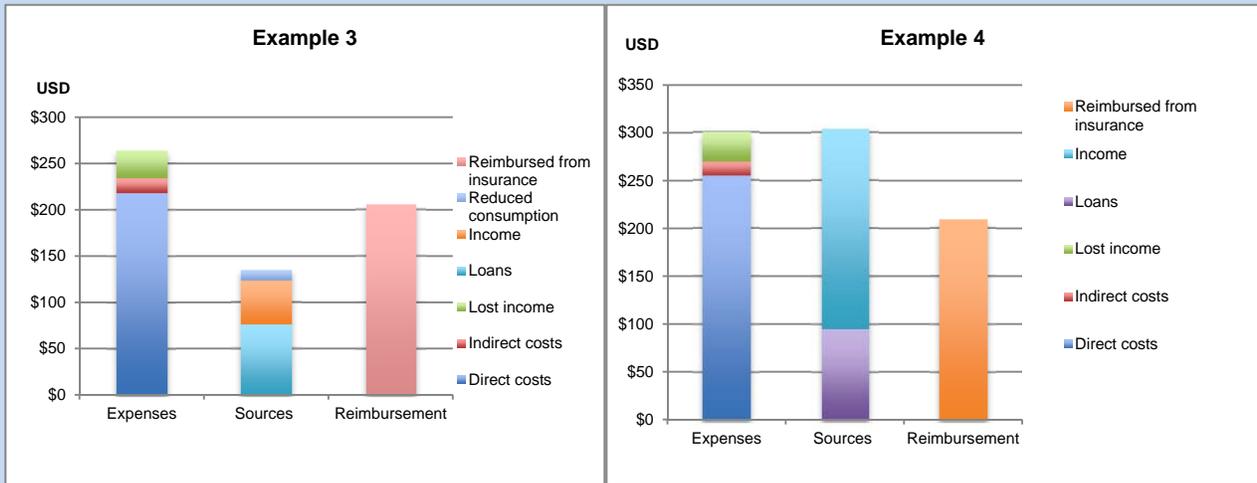


Example 3 illustrates the case of an insured male farmer who owns a large, 50-acre plot of land. He heads a household of four people and is the main source of income for the household, drawing a monthly income of roughly USD133, supplemented by USD29 from others in his household. He reported his household expenses at only USD11 per month, perhaps because the family relies on food produced on their farmland and barter necessary items with their neighbors. The respondent has an outstanding loan of USD760 from SDCCB, which he considers to be the cheapest source of borrowing available. He contracted malaria in July 2011 and was hospitalized. He was not able to claim a cashless benefit but instead received reimbursement. He incurred high direct costs of USD219 at the hospital, largely spent on doctor's fees, hospital stay and laboratory tests, as well as indirect costs of USD15. He missed five days of work and estimated his lost income at USD30. He financed his cumulative expenses of USD264 from various sources, including USD48 worth of income, USD76 as an interest-free loan from friends, and by reducing his consumption of medical care worth USD11 for three weeks after the hospitalization. He received a reimbursement of USD205 from the insurance company four weeks after his discharge. The respondent had to bridge a financing gap of nearly USD130 during this four-week waiting period (see Chart below), and likely did so by utilizing a larger portion of their household's income than reported (their net income after expenses was USD151), paying the hospital in installments or missing a loan payment to SDCCB. Needing to wait for the reimbursement seemed to have limited impact on his household finances or perceptions of insurance. He reported that he was satisfied with the health cover offered through SDCCB and said he would be willing to pay a premium in the future.

In our final case, **Example 4**, we speak with a 32-year old woman respondent who is the head of a farming household of 5 people, and a subscriber of the health insurance with SDCCB. The family owns three acres of land and draws in USD209 per month, approximately half of which is the respondent's income. The respondent has an outstanding loan of USD570 with SDCCB, presumably used to maintain the farm and help smooth household cash flows. She was hospitalized for gastroenteritis in June 2011 and admitted to a hospital that she had visited previously. She was required to pay upfront for her treatment. Her direct costs at the hospital were relatively high at USD255; this was spent largely on administrative and doctors' fees (USD115) and just over USD75 on medicines, laboratory test and supplies combined, with the balance covering assistance from hospital staff and hospital meals. Her indirect costs amounted to USD15, spent on transport and her special diet upon release. The respondent missed eight days of work that cost her USD30.



Although she was accompanied by her husband, brother and mother she did not report any additional lost wages in the household. The respondent dealt with her hospitalization expenses by borrowing (interest free) USD95 from family and friends and diverting the equivalent of one month's household income to finance the illness. She received a partial cash reimbursement for USD209 from United Insurance India four weeks after her hospitalization. While she considered having to put the money up in advance inconvenient, the household appeared able to cushion these expenses relatively easily and did not report reducing household consumption. This respondent believes that insurance can protect one's income as well as offer peace of mind and improved access to health care; she would like to renew coverage and is open to paying a premium in the future.



Was it worth it?

The insured were better able to finance the shock, but the difference appears to be more a factor of access to credit than to insurance.

Respondents in our Solapur-district sample who underwent hospitalization all went through some financial stress: the shock cost on average over one month's household income. They were offered a free insurance product through their borrowing relationship with SDCCB, and received value from the USD51 average payout offered as a reimbursement to their hospitalization costs. This reimbursement was relatively small, however, compared to the full cost of the shock. On average, the insurance paid for 53% of the direct costs of the hospitalization (though this varied case-by-case) but only 25% of the total costs for the insured, leaving a large portion of the cost that needed to be financed through other means. Claims settlements were made on average after 14 weeks. Nevertheless, the insured families demonstrated substantial capacity to cover their financing needs through their income and debt financing and, for the most part, did not resort to using difficult coping mechanisms such as reducing consumption. A key distinguishing factor for the insured seems to have been their greater access to formal credit and ability to turn to friends and family for shorter-term loans to finance their health crisis. The uninsured, on the other hand, though they experienced lower costs, were more likely to reduce household consumption, utilize income from others in their household and take cash advances from their employers.



A client of SDCCB after a hospitalization

Experience with the product seems to have increased demand and willingness to pay.

With tiny premiums covered by their lender SDCCB, clients perceived the product as valuable in offering some financial relief, even though our "Client Math" shows the relief to have been small relative to their total



financing needs. All SDCCB clients who had made claims and were reimbursed reported that they were satisfied with the product and that they would like to renew it, and many showed willingness to pay the premium. Given that the alternative to having insurance was to pay for the entire costs of the hospitalization, this is not altogether surprising. It does suggest, however, that the experience of having insurance and making a claim may help clients perceive its value more tangibly. Previous research has found that experience or familiarity with an insurance product may strengthen demand by ensuring that clients understand it and trust that it will work as promised (Giné et al., 2008; Donfouet & Makaudze, 2010).¹⁵ Interestingly, few of the uninsured respondents had been offered insurance, and those who had cited a lack of familiarity as a reason for not buying it.

In separate surveys of clients who were insured but had not made claims, MicroEnsure found client satisfaction and awareness to be low. In response, MicroEnsure has been sensitizing and training SDCCB staff to improve their awareness of the benefits of the cashless system, while in turn working to strengthen the cashless benefit. To achieve the latter, MicroEnsure has implemented measures to strengthen the preparation and training of Health India TPA to work with providers and has provided additional Customer Relationship Officers (CROs) to help clients through the claims process.

Complementary coverage for lost income may improve value.

We found that for the poor farming households in our sample, some of the most significant costs associated with health crisis are incurred outside the hospital setting in the form of indirect costs, in particular the costs associated with their inability to work and having to hire day laborers in their place. With the ongoing scale-up of RSBY and other publicly sponsored health schemes in India, where millions of poor families can access limited inpatient health coverage, there are opportunities to explore synergies that can ensure a more expanded range of health coverage for the poor. Such coverage may encompass both direct hospital costs and indirect costs, such as the lost income that were so significant for the respondents in our study.

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Microinsurance Learning and Knowledge (MILK) is a project of the MicroInsurance Centre that is working collaboratively to understand client value and business case in microinsurance. Barbara Magnoni leads the client value effort and Rick Koven leads the effort on the business case. For more information contact Michael J. McCord, the project director, at mjmccord@microinsurancecentre.org.

¹⁵ MILK Brief #7: A microinsurance puzzle: "How do demand factors link to client value?" explores this and some of the many other factors that may influence demand for microinsurance.