

Reaching financial stability and building capacity

David M. Dror, PhD, DBA

*Presentation at the International Conference
on Developing Micro Health Insurance for the Poor
(New Delhi, 1& 2 November 2006)*

Kindly supported by



The two challenges ahead

- Micro health insurance should perhaps be not-for profit, but also not a loss-making undertaking. Hence the concern about financial stability. The challenge: **REDUCING PREDICTABLE MARKET FAILURES BY A NOVEL DESIGN OF THE BUSINESS MODEL**
- The evaluation of what is “low-premium and high quality” product rests with the clients. Their involvement in the process can create a bigger buy-in AND reduce administrative costs. The challenge: **BUILDING CAPACITY AMONG GRASSROOTS COMMUNITIES TO FULFILL THESE FUNCTIONS**

Why bother doing it?

- Because we know that **all alternatives** (do nothing, top-down decisions etc) **lead to polarization** in the conditions of the underserved vs. the served, with the resultant serious social and economic risks
- Because we know that the rural and **needy populations are willing to pay realistic premiums** for health insurance, provided that:
 - The H.I. product(s) responds to **their priorities**
 - That **they are involved** in the rationing decisions
 - That the process supports the time-tested rationale of **community choices to the detriment of the choices of benefit-maximizing individuals**

What is “an attractive H.I. package”?

- Our study showed that people seek **protection against expensive care**, not merely rare care. Frequent events that aggregate to high costs must be covered;
- people prefer coverage of a **broad range of benefit types at lower level of coverage**, rather than high coverage of a narrow range of risks. Such holistic coverage is a wise method to diversify risk-exposure

Reality check in the Indian H.I. market

- **None** of the health insurance products available on the market at present includes the benefits includes the holistic coverage, and none of the products can claim
 - Inclusion of the most costly risks
 - Inclusion of the most risky population segments
 - Inclusion of people “as is” (including their pre-existing conditions)
- Most products are neither
 - Simple to understand
 - Cheap (for what they cover)
 - Based on evidence of the clients’ needs / priorities
 - Adapted to the way financial decisions are taken in the Indian (rural) society

Avoiding (or reducing) market failure (1):

Adverse selection / cherry picking

- The broader the affiliated group, the better the likelihood of risk diversification (= lower average. cost of the risk)
- In India, most financial decisions are taken not by the single earner but by a larger networks of “dearest and nearest”
- Therefore, the affiliation unit must include the entire community, joining en-bloc, rather than individual affiliation
- **Community-based affiliation reduces both adverse selection and cherry picking, and thus costs.**

Avoiding (or reducing) market failure (2):

Cherry picking of good risks by insurers

- Most countries disallows insurers to exclude MOST OF THE LIKELY RISKS
- In India, the regulations allow insurers to select good risks by restricting the coverage according to age-groups, or excluding other vulnerable groups (maternity, “pre-existing conditions”).
- The solution to this market failure is
 - Regulation obliging insurers to include more risks
 - A health insurance package that includes all persons. Such a products will emulate the normal social practice of families taking care of their weaker elements (children, women in maternity, older persons, chronically sick)

Avoiding (or reducing) market failure (3):

Reducing efforts (& cost) to collect premiums

- When a community joins en-bloc, it is also possible to require it to pay the premium en-bloc
- Intra-household and intra-community distribution are a matter of the community, not the insurer.
- The process can be facilitated when each community sets up a committee to collect the premiums.
- Localization of the responsibility opens up options of collecting smaller amounts on a daily, weekly or irregular basis, and enables intra-communal redistribution and smoothing of fluctuations in cash-flow.

Overcoming distrust in insurance (1)

- Make insurance relevant, by providing choice.
 - The attractiveness of the insurance product depends on how well it deals with local needs and demand.
 - Illness, needs and general conditions vary greatly due to different life-styles, epidemiological profiles, availability of medical providers, different cultural values.
- **One product does not fit all!!**

Overcoming distrust in insurance (2)

- **Keep it simple**
- People know well their “community culture” and local, unwritten rules of conduct. Insurance must be integrated in this context
- **Keep it local**
- In order to mobilize social capital the insurance needs to be part of the community; critical interactions must occur locally, with people from the community.

Making it happen: Capacity building

- Training must be based on **what people know**, rather than on what they don't
- Training must focus on **what works**, not on theory
- Training in Micro Health Insurance should be the **main focus of the trainer**
- This requires setting up an Academy for Micro Insurance (**AMI**)
- **AMI** must (and will) function in the local languages
- **AMI** will focus only on operating micro insurance scheme
- **AMI** will teach **only** the operations that are carried out at the level of the community: affiliation, premium collection, dissemination of information on rights of insureds, record-keeping



Kindly supported by



SOCIAL RE
Reinsurance for Community Health Schemes

Making it happen: Aggregating risks

- Micro health insurance units are small; their size and limited geographical spread increases their vulnerability
- Pooling of many small communities into one large “group” increases statistical diversification, lowers the cost of risk, and mainly the risk of “long tails”.
- In the India context, such pooling requires linking MIUs to reinsurance (GIC). GIC needs a “front-end” insurer to work with.
- The business model of this “solidarity insurer” will be
 1. non-profit (and no loss either)
 2. inclusive affiliation (all age groups)
 3. affiliation of communities only
 4. Community-determined packages and coverage level (CHAT method)
 5. Core activity (H.I.) will be supplemented by value-adding components (e.g. MNS, preventive screening etc)
 6. Accessory activities will be done by others (under coherent contracting): IT, connectivity, community-health, reinsurance, etc.



Kindly supported by



SOCIAL RE
Reinsurance for Community Health Schemes

Questions? Comments?



More details on our website
www.microhealthinsurance-india.org



Kindly supported by



SOCIAL RE
Reinsurance for Community Health Schemes