Addressing the Value and Viability trade-off in health insurance

A case study on Uplift Health Mutuals

June 2013

Rupalee Ruchismita, Dr. Saurabh Sharma and Dr. Altaf Virani
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This case study on the mutual model of Health Microinsurance facilitated by Uplift India Association (UIA) has been prepared by a team at CIRM, consisting of Dr. Saurabh Sharma and Dr. Altaf Virani. The work was carried out under the general direction of Rupallee Ruchismita. It was commissioned by the Microinsurance Innovation Facility (MIF) at the International Labour Organization (ILO).

The team undertook a wide range of consultations for this Case Study. The Uplift India Association (UIA) and its member organizations shared vital information. Helpful review and comments were provided by Kumar Shailabh, François Xavier Hay, Anne Claire Hay, Dr. Medha Purao Samant, Dr. Deepali Kulkarni, Dr. Abhijeet Sale, Dr. Amit, Vrushali Vengurlekar, Vasanti, Anita and Eamon Kelly. Client narratives were facilitated by Annapurna Parivar Vikas Samvardhan (APVS) and Parvati Swayamrojgar (PSW) and MIF, ILO Fellow Joyce Tong sharing her views and portfolio analysis of the organization.

We would like to acknowledge the support of Pranav Prasad, Michal Matul and Jeanna Holtz from the Microinsurance Innovation Facility at ILO for facilitating this engagement.
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Abbreviations

NSVK Navnirman Samaj Vikas Kendra
PSW Parvati Swayamrojgar
RSBY Rashtriya Swasthya Bima Yojana
APVS Annapurna Parivar Vikas Samvardhan
AMMCCS Annapurna Mahila Mandal Credit Cooperative Society
UIA Uplift India Association
HMF Health Mutual Fund
PREM People’s Rural Education Movement
A demand driven micro health insurance market is one of the biggest opportunities to improve access to healthcare in developing countries. However, the penetration of health insurance at 25% in India1 (considered the fastest growing and the largest microinsurance market) is still dismally low as most of this is achieved through Government subsidized schemes. A range of community-owned health mutuals have been engaged in addressing this challenge and facilitating health provision, but there is limited evidence that scale and sustainability have been achieved.

In India, the government has launched a series of ambitious health financing programs in partnership with the private sector. However, there is a conspicuous absence of collaboration with the social sector. Thus, it is imperative to identify if there are valuable lessons the sector can learn from the mutual model. In 2010, CIRM was asked by the MIF, ILO to conduct a detailed assessment of the community-managed Uplift model, to explore its client desirability and viability. CIRM conducted this case study through two approaches:

a. A detailed process evaluation to measure process robustness and readiness for replication was undertaken. This was supported by an assessment of the identified opportunities for scale.

b. The second approach was programmatic and included the analysis of available client feedback and data on the overall welfare impact on the client’s health expenses.

With this approach in place, attention was turned to data collection. The Team conducted the first wave of assessments through multi-level interviews. This involved community meetings, partner interviews, and processing organizational documents and insurance data.

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1 “A Critical Assessment of the Existing Health Insurance Models in India” by Public Health Foundation of India (2011)
Specific areas of interest identified for the sector are:

Increased enrolments and re-enrolments within member organizations even when membership to the insurance scheme was voluntary.

Health services offered in-patient hospitalization insurance cover supplemented with discounted drugs, diagnostics, and out-patient care.

Understanding the model which creates the above conditions could help achieve greater scale and greater ease in replication of Microinsurance programs across developing countries. The insights and lessons learned through Uplift’s organizational transition to cope with scale may be applied across the health insurance space. This case study demonstrates that Health Mutuals such as Uplift could achieve sustainability while maintaining high client desirability through higher partner level client saturation and healthcare cost containment. This could be done by collaborating with public healthcare providers. Moreover, by providing value-added services, re-enrollment increases, which leads to overall cost reduction – saving precious marketing costs. In addition, Uplift can be credited for detailed documentation of its process management, led by ‘community decision making’. This allows for ease in decentralized accountability for insurance fraud management and replication – both of which are critical additions to the health insurance space to ensure greater momentum towards universal access to health insurance.
With public health spending falling in developing countries, the load on individual households to finance costs of healthcare has never been more urgent. Even though India has been an exception, with its sudden increase in health insurance access, this scale is driven mostly by government-subsidized products and not through voluntary take-up. Bulk government purchases have been valuable in achieving scale. However, these products suffer from lack of user-feedback or ownership. This tends to increase leakages in the schemes and reduce overall quality of care and program viability. Market-driven voluntary Microinsurance models have been rare, and have not demonstrated client desirability or sustainability.

In this scenario, the various strengths of mutual health Microinsurance schemes, such as the ability to identify specific needs of the target group, to achieve higher levels of trust among members, to practice social control in order to reduce fraud and moral hazard, and to create insurance awareness (Patel, 2002) have not been harnessed to their full potential in the recent past. However, even these mutual schemes have continued to face constraints, such as non-availability of trained human resources and poor access to reinsurance. These factors hamper growth, and lead to low membership of health mutuals, thus affecting scale and sustainability (Matul & McCord, 2010). The growth of the Uplift model could contain significant lessons for the sector in India and other developing countries.

Established in 2004, Uplift India Association is a non-profit network body working towards developing community managed social protection programs. The group initiated a community-based health fund – Uplift Mutuals – to make quality healthcare accessible to its members.

With these considerations, CIRM conducted a study to gain insights into the operational processes of Uplift Mutuals. This study documents innovations and defines key characteristics of the program, while drawing lessons in terms of client desirability, viability, scalability, and prospects of replication.

This paper is organized as follows: Section 1 describes the organization, Section 2 describes the product, and Section 3 discusses the various processes. We look at some performance indicators for the scheme in Section 4. Section 5 measures the impact in terms of client value and sustainability. In Section 6 and 7 recommendations and sector level learning are discussed.

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4 The founding members of UIA identified lack of access to affordable and quality healthcare services, low health consciousness, and financial burden of medical expenses as the major causes for poor health standards, while working with low-income communities. In order to address these issues, they conceived a community-based health mutual fund as a viable means of reducing risk sensitivity caused by health-related expenses, and providing quality healthcare at affordable prices.
By 2012, more than 160,000 Uplift members had enrolled for its Health Mutual Fund (HMF) services. The operational structure of Uplift Mutuals focuses on community involvement, reflected in the annual product design process as well as in the day-to-day management of the program, especially claims processing. This involvement helps in creating and maintaining a sense of ownership among stakeholders. Uplift services clients by leveraging the partner organizations that work with the community. Additionally, insured members are supported by service executives, or Arogya Sakhis, who follow predefined standardized processes to improve overall efficiency. These executives are also involved in the delivery of healthcare services, which helps in improving the client desirability of the program.

Uplift Mutuals is currently experiencing an organizational growth phase.

The Uplift Model

In pursuit of sustainability

The Uplift program is able to meet the claim settlement fund requirement and part of the program management cost. However, it relies on grants to finance the provision of ‘value-added healthcare services’ and to fund part of the program management cost. The contribution of grants towards Uplift’s service and administration expenses decreased from 45% in 2008 to 31% in 2009, indicating improvements in overall operational efficiency.

The value added services add to the program cost but they are the key for the long term sustainability of the program due to their risk reduction ability. These risk reduction interventions seek to improve the overall health stock of the community leading to lower health expenses at the household level and could lead to reduced hospitalization claims of the mutual fund. This has high client value and also contributes to long term financial sustainability, curbing health costs. Forging partnerships with new implementing partners is another key to sustainability. Both scalability and Replicability may be restricted to organizations that have an organizational philosophy and structure compatible with the UpLift model. Since the model is a demand driven effort, it has to bear the time cost of community education before scale is achieved.

UIA has tracked the impact of these ‘add-on’ services. The results show a reduction of 16% in members’ out-of-pocket healthcare expenditure in a year (tracked from 2008 to 2009).
Health insurance schemes use a range of methods to deliver services. A set of criteria that is sector-accepted, encompassing factors considered important, is used to evaluate and compare these models. To help understand the variety of experiences of the client with each of these service delivery arrangements, the sector has for the most part considered two broad categories as critical – the social impact of the scheme, and the viability of the program.

This case study follows this line of analysis and considers two categories – client desirability, as well as sustainability and replicability – to evaluate the model. These criteria make it easier to evaluate different components of a model.

**Client Desirability**

Low take-up and re-enrolment are considered to be key measures to indicate that the perceived value of insurance solutions by low-income households is low. Subsidized schemes have few alternative measures to evaluate the programs’ client desirability. This section unbundles the aspects of the model that are desirable to the client, which can be categorized into three categories

a. Improved servicing of in-patient hospitalization cover through improving accessibility, faster health referrals, and faster claim resolution
b. Responding to clients’ more common, moderate health risks, by providing discounted out-patient consultation, drugs, and diagnostics
c. Approaches to track and further improve impact on client

**Sustainability and Replicability**

With the exception of compulsory or subsidized schemes, there are few sustainable health insurance schemes for low income households. This section analyzes the programme on two categories: a) programmatic partner- and service-level income and expenses b) efforts undertaken to improve sustainability and replicability.
Established in 2004, Uplift India Association (UIA) is a group of social sector organizations collaboratively developing community-owned and -led social protection models. Uplift Mutuals is the flagship program of Uplift India Association formed by coming together of five non-profit organizations in 2003 which then joined UIA when it was registered in 2004. Later in subsequent years, four other non-profit organizations joined in. Currently, the group has 9 members, with PEDO being the latest partner since 2012.

Uplift Mutuals provides TPA (Third Party Administrator) services; technical inputs to partner organizations in setting up and managing health mutuals for low-income groups.

The Framework of Relationship between TPA, Member Organizations, Technical Support Providers and Funder

The partnership has three categories of members. Their roles and relationships are highlighted in this section.

Uplift TPA: Uplift provides technical, operational, and managerial support to its partner members. This support includes assistance with business planning, governance, human resources, management training, financial planning, management information systems, design of products and processes (research and analysis along with benchmarking and quality control), community education, and social performance evaluation. Acting as a traditional Third Party Administrator (TPA) for the program, Uplift undertakes claim-checking by in-house medical professionals, bearing related operational costs, and also takes on the task of monitoring and evaluating networked hospitals.

Member organizations: These organizations are client aggregators and are engaged in providing one or more social services in their command area. The most common services offered are micro-credit, support for enterprise development, and family development programs. These organizations house the health mutual and provide assistance in facilitation as well as oversight support.

Support organizations (Inter Aide and Swabhimaan): Inter Aide and Swabhimaan are founding members of Uplift. Inter Aide supports the program in the member organizations by providing funds to meet programmatic operational expenses. Swabhimaan houses Uplift at its Pune office, providing infrastructural support.

Organizational Set-up

Uplift’s model is based on leveraging the capacity of member organizations for opera-

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5 Namely Swabhimaan, Inter Aide (www.interaide.org), Navnirman Samaj Vikas Kendra (NSVK), Parvati Swayamrojgar (PSW), and Annapurna Mahila Mandal Credit Cooperative Society (AMMCCS), Chaitanya, and DISHA. People’s Education and Development Organization (PEDO) supported federations joined in 2012.

6 The second set of partners was Disha Kendra, Annapurna Mahila Mandal Credit Cooperative Society (AMMCCS), Chaitanya, and DISHA. People’s Education and Development Organization (PEDO) supported federations joined in 2012.

7 This comprises providing funds and skill development to individuals to form small enterprises and businesses.
tions at the community level, while the TPA arm undertakes specialized insurance activities. Uplift’s insurance operations ride on the core activities of member organizations, such as micro-finance and other development projects. For specific services, Uplift Mutuals, the TPA set up, allocates its own Arogya Sakhis (Service Executives) and their Supervisors to interact directly with members of the partner organizations. The field staff works under an Assistant Manager and Manager.

Uplift Mutuals’ Supervisors report to the Assistant Manager, who is responsible for monitoring program implementation, as well as compliance with the processes laid down by program administrators. The Manager reports directly to the Managing Director of the implementing member organizations, and liaisons with the process managers at Uplift.

Membership
There are two criteria to qualify for organizational membership:

- Sharing a common vision of community ownership of health mutuals, and
- Having regular and direct communication with the organization’s own members.

UIA conducts detailed feasibility studies to understand the background and profile of prospective member organizations before forming new partnerships. An organization, once identified as a partner, contributes equity and signs the UIA Common Charter.

Region
UIA has mostly followed an urban model, expanding in the city of Pune (now also operational in rural regions) and in Mumbai, with operations extending to the Marathwada region of Maharashtra, in Western India; parts of Tamil Nadu, in Southern India; the metropolitan city of Kolkata in West Bengal, in the east; and Dungarpur in Rajasthan, in the north-west.

Target Market
The program’s target community comprises both the urban and rural poor, who have little or no access to social protection schemes and formal credit.

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8 All shareholders have voting rights and the shares are priced at INR 10 each (USD 0.22).
9 Each member organization is autonomous in its functioning; having a separate legal status and governing structure.
10 Those with a per capita income of less than Rs. 2500 (USD 50) per month.
Arogya Nidhi was established as the flagship in-patient hospital insurance product of Uplift Health, and was offered from 2003 to 2006.

As of 2012, more than 160,000 individuals had pooled their risks in the Health Mutual Funds (HMFs), which are funded through contributions by enrolled members. Table 1 presents the product features of Arogya Nidhi II, the current scheme. The product covers basic in-patient treatment in general wards including specific pre- and post-hospitalization expenses.

2.1 Coverage

The program offers reimbursement for claims based on the extent of the health cover. Like other schemes, including mutuals such as PREM and Karuna Trust and state-funded schemes like RSBY, this program encourages claimants to visit government hospitals for treatment in order to maintain affordability. However, while government hospitals charge less (thereby contributing to the financial sustainability of the program), the high traffic, absenteeism of doctors, and absence of medical consumables has led to a poor perception of the quality of services provided. Wherever possible, the program leverages local government social workers to facilitate easy hospitalization of members and align necessary medical supplies for surgical procedures.

Catering to Exceptions: The program has provisions for exceptional cases where

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**Figure 1: Evolution of Uplift Insurance Product**

- **2003** Arogya Nidhi launched
- **2007** Revised to Arogya Nidhi I Premium: Rs. 60 (USD 1.2) Coverage: Rs. 5000 (USD 100)
- **2008** Premium revised to Rs. 100 (USD 2) Coverage: Rs. 15000 (USD 300)
- **Mid 2008** Arogya Nidhi II launched Premium revised to Rs. 150 (USD 3) with same coverage
### Table 1: Product Features of Arogya Nidhi II

<table>
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<th>Target Segment:</th>
<th>The unorganized sector (including those below the poverty line, slum dwellers and microcredit clients of implementing partners)</th>
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<tr>
<td>Compulsory/Voluntary</td>
<td>Compulsory for MFI credit customers of member organizations</td>
</tr>
<tr>
<td>Payment Type</td>
<td>Reimbursement</td>
</tr>
<tr>
<td>Eligibility Criteria</td>
<td>All members of a family must enroll for a family to be eligible. A family is defined as a couple whose first two children are below 18 years of age. Couples without children, dependent parents, siblings, etc. are considered to be individuals. There is no age limit for enrolment, but the age of the policy holder should be above 18 years. No health check-up is required for enrolment.</td>
</tr>
</tbody>
</table>
| Premium Contribution | For a family of four: Rs. 400 (approx. USD 8) per year  
For individuals: Rs.150 (approx. USD 3) per year |
| Period of Cover | 12 months from the date of issue of policy |
| Sum Insured | Rs. 15,000 per person per year, subject to policy exclusions and stipulated sub-limits |
| Coverage | In-patient hospitalization expenses for treatment in the general ward of networked hospitals (Uplift has a network of 300 providers)  
10 days of pre- and post-hospitalization cover including one-time expense for diagnosis of the ailment, and the cost of medicines prescribed for consumption during this period  
Pre-existing diseases covered from the third year onwards  
Referrals through a 24x7 telephone line  
Discounted out-patient services at networked practitioners through OPD discount coupons  
Discounted diagnostic services at networked providers  
Periodic health camps and talks on prevention and health promotion  
Weekly branch-level OPDs and provision of some free generic medicines |
| Stipulation Pertaining to Healthcare Providers | Reimbursement of 100% of the claimable amount if treatment is sought at a public hospital and 80% of the claimable amount if treatment is sought at networked private hospitals empanelled under the scheme  
No reimbursement if treatment is sought at a non-networked private hospital, except in cases of emergency treatment; this is however subject to the decision of the claims committee |

2.2 Premium

Uplift charges Rs. 150 (USD 3) per year for an individual, or for each family member, if the family size is limited to two. Group membership is encouraged, as it reduces the risk of adverse selection. The premium for a family of four, therefore, is Rs. 400 (USD 8) per year. The sum assured per person per year is Rs. 15,000 (USD 300). There is no age restriction to enroll in the scheme, making it one of the few schemes covering senior citizens with no additional premiums. However, the cover of Rs. 15,000 (USD 300) is lower than the coverage limits of other similar schemes (usually between Rs. 20,000 (USD 400) and Rs. 30,000 (USD 600) per year).

2.3 Claims and Network of Care Providers

Clients are encouraged to avail treatment at government-run hospitals or trust-run hospit-

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11 Uplift intends to increase the coverage in the future through service provider negotiations.
### Table 2: Package of Value-added Health Services

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<th>Details</th>
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<td>Out-patient care</td>
<td>A full-time doctor visits Member NGO branches on a weekly basis. Members can access the doctor for medical consultations or health queries.</td>
</tr>
<tr>
<td>Discounts on drugs and diagnostics</td>
<td>Availed at empanelled pharmacy and diagnostic centers. Some free generic medicines are also provided.</td>
</tr>
<tr>
<td>Health camps</td>
<td>Health awareness sessions are organized by NGOs and conducted by a doctor from a network hospital or service provider.</td>
</tr>
<tr>
<td>Health talks (only for members of the NGO PSW)</td>
<td>Health awareness sessions are run by the service executives on general health topics.</td>
</tr>
<tr>
<td>Client education (only for APVS Pune and Mumbai members)</td>
<td>Information sessions about insurance and the HMF program (for PSW members, this information is disseminated as part of enrolment).</td>
</tr>
<tr>
<td>24x7 helpline</td>
<td>The helpline is manned by a doctor primarily for guidance or referrals in cases of hospitalizations, but can also be used for general guidance or referrals in less serious health situations.</td>
</tr>
<tr>
<td>Access to Uplift’s network of HCPs</td>
<td>Uplift has established a network of more than 300 Healthcare Providers for better quality of care, and to control cost. Uplift signs MoUs with negotiated medical costs with these providers.</td>
</tr>
<tr>
<td>Referrals/guidance</td>
<td>A Service Executive follows up cases where a member accesses the 24x7 helpline for hospitalization, and provides assistance.</td>
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</table>

Uplift has identified low awareness and poor health standards in the target community as key risks to its model. Therefore, its insurance coverage is complemented with other ‘value-add’ services which provide tangible benefits more frequently, and contribute to the improvement of the health status of the community. These additional services, presented in Table 2, could improve program take-up and viability. These services increase the client perception of the scheme as well as the value of the insurance product. This package is unique among voluntary community-managed micro health insurance programs.

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12 The healthcare package sought to improve the overall health stock of the community, leading to lower health expenses at the household level, and therefore reduced hospitalization claims to the HMF. This has high client desirability, in addition to contributing to the long-term financial sustainability of the HMF by lowering health costs.
The key processes can be categorized into three categories:

**Awareness creation:** Creating awareness is the most critical process, as a community model depends on community understanding and decision making.

**Traditional insurance delivery processes:** This process involves insurance enrolment and renewals.

**Claim processing:** This is done with the cooperation of the community, and is led by the claim committee.

### 3.1 Awareness Creation

There are several aspects of client education and awareness, which have been categorized below based on the sequence in which they are implemented.

**Information and training:** Uplift and partner organizations provide information regarding Arogya Nidhi funds and organize governance meetings in order to ensure ‘informed ownership’ by the communities. Monthly committee meetings and training sessions for elected representatives are organized to improve unbiased decision making. Attending members are given information about HMFs through posters and charts, to reduce the risk of miscommunication.

**Promotion and orientation:** The Uplift TPA set up, trains and educates the field staff of member organizations and provides advertising material for community events organized by them for insurance promotion. At partners’ ‘group meetings, the trained staff of the partner organization introduce the product to attending members, detailing the various features and benefits of the product including the value-added package. These meetings also help in exploring the health-financing needs of members and identifying if the mutual model would be a preferred solution. In some cases, these events also enable communities to express solidarity by collectively reducing the impact of catastrophic illnesses. Members are encouraged to invite their spouses for follow-up meetings to reinforce prior decisions, promote wider discussion, and to clarify doubts. A preliminary list of willing members is drawn up and a date is fixed for enrolment processes, including collecting the premium and family photographs for the insurance cards. Arogya Sakhis attend select group meetings, mostly loan disbursement meetings, as part of the campaigning effort.

**Arogya Nidhi card distribution:** Another critical awareness effort involves community education regarding the relevance and usage of insurance cards, while the cards are being issued. The Arogya Sakhis welcome members into the fund, and provide detailed information on the policy, use of referrals and claims.

**Accessing care:** The support services offered by the program through its Arogya Sakhis at public health facilities include:

Guiding the clients to networked hospitals in case of sickness.
Informing clients on the usage of services, network hospitals and referral services, health check-up camps, health talks
Encouraging the use of the 24x7 helpline for consultation and guidance

Claim meetings: Unique to mutual models are the community claim settlements. Member education becomes crucial in making these processes reliable. During claim meetings, members are supported in completing the documentation required for submission of claims.

3.2 Enrolment and Renewals Procedure

The enrolment process involves the issuance of a Nidhi Card, to be used to obtain services from empanelled care providers. The entire process is clearly predefined to improve overall efficiency.

The Uplift TPA team trains the Arogya Sakhis and provides them with enrolment forms and cash receipt books. This is followed by enrolment visits. Every month, the Arogya Sakhis attend partner community meetings, where premium collection and enrolment application takes place. To ensure client protection, premium receipts are issued in triplicate – one copy for the enrolling member, one copy for Uplift, and one for the issuing branch. Following this, cards and coupons are issued. The photographs and forms are sent by the branch offices to Uplift, where the information is digitized by the Business Process In-sourcing (BPI) department. Nidhi Cards and OPD coupons are issued by the BPI team and follow the data channel to be re-distributed to the clients. Information about any necessary upcoming renewals is communicated to the Arogya Sakhis through a Policy Description Report (PDR), generated by Uplift TPA three months prior to the policy completion, to contact members for policy renewal.

In case of products linked to loans or savings, renewals are done automatically when the payment is transferred to the Nidhi fund from the member’s savings account on the due date, or when a fresh loan is availed.

For voluntary cases, the Arogya Sakhis conduct home visits seeking renewals.

Any changes in household policy membership are noted and communicated to Uplift TPA along with renewal premiums, enrolment forms, and consolidated branch-wise collection reports. The information is updated in the system, and fresh Nidhi cards are distributed to re-enrolled clients through the same channel.

Nature of Enrolments: The fact that enrolment is compulsory for members of some organizations has helped the program to achieve scale.

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**Arogya Sakhi makes it happen:**

**Role of Arogya Sakhi (Service Executives):**

Their responsibilities include:

- Conducting orientation meetings for enrolment (during group loan meetings in member organizations delivering micro finance services)
- Conducting client enrolments (cash collection, policy issuance documentation, receipt generation, distribution of policy cards)
- Provision of referral services (providing preventive and promotive health education, facilitating care for referred cases and patients admitted to emergency wards, by networking with health service providers, and assisting in claims settlement)

**Role of Supervisors:** The Supervisors are responsible for ensuring that the Arogya Sakhis effectively carry out their duties in accordance with their pre-defined roles. They are also responsible for monthly planning, provision of training and guidance, and regular auditing of field processes. Four to six Arogya Sakhis report to one Supervisor.
3.3 Claim Settlement

The process of claim settlement includes a two-stage process of medical validation by in-house medical professionals of the Uplift TPA, followed by claim decision-making by community members. A decision is made both on whether the claims are to be approved, and the settlement amount. These decisions are supported by a preset decision-making tool, with parameters such as disease category and type of hospital. Elected representatives from each branch meet on a monthly basis for claims adjudication. The identity of the claimant is not revealed, in order to avoid bias.

Reimbursements can take 30 to 40 days from the date of a member filing a claim.

3.4 Centralized Risk Pooling to make the fund more robust

A decision was taken to implement centralized risk pooling and risk management at Uplift, to address the perceived high build-up of surplus funds in individual Arogya

Facilitating Community’s Claim Decision Making

In order to ease the process of community decision-making, Uplift TPA engages in assessment of the validity of the claim. At Pune, the process consists of the following stages:

Medical scrutiny and procedural validation is carried out by the medical officer at Uplift TPA. A preliminary decision regarding the validity of the claim is made in accordance with policy regulations.

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Name</th>
<th>Location</th>
<th>Year of Joining</th>
<th>Nature of enrolment (Voluntary/ Compulsory/Both)</th>
<th>Total</th>
<th>Voluntary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Swabhimaan-Antyodaya</td>
<td>Pune, Maharashtra</td>
<td>2013</td>
<td>Compulsory with loans but membership also possible without loans.</td>
<td>9902</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Navnirman Samaj Vikas Kendra</td>
<td>Mumbai, Maharashtra</td>
<td>2011</td>
<td>Compulsory with loans but membership also possible without loans.</td>
<td>8105</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Parvati Swayamrojgar</td>
<td>Pune, Maharashtra</td>
<td>2004</td>
<td>Compulsory with loans but membership also possible without loans.</td>
<td>24240</td>
<td>Segregated data not available but maximum 10% of total ongoing members.</td>
</tr>
<tr>
<td>4</td>
<td>Annapurna Parivar Vikas Samvardhan</td>
<td>Pune, Maharashtra</td>
<td>2003</td>
<td>Compulsory with loans.</td>
<td>57813</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Annapurna Parivar Vikas Samvardhan Society</td>
<td>Mumbai, Maharashtra</td>
<td>2003</td>
<td>Compulsory with loans.</td>
<td>47270</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Premseva</td>
<td>Mumbai, Maharashtra</td>
<td>2012</td>
<td>Compulsory with loans but membership also possible without loans and through savings.</td>
<td>5585</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Chaitanya</td>
<td>Pune, Maharashtra</td>
<td>2010</td>
<td>Voluntary.</td>
<td>4627</td>
<td>100%</td>
</tr>
<tr>
<td>9</td>
<td>PEDO-supported Federations</td>
<td>Rajasthan</td>
<td>2012</td>
<td>Voluntary.</td>
<td>5369</td>
<td>100%</td>
</tr>
</tbody>
</table>
Nidhi accounts and the need for improved risk management. The following three components are to be implemented:

Pooling of funds centrally rather than at each NGO’s Arogya Nidhi account, as is currently the case; however, claim decisions will continue to be branch-based.

Establishing a “solidarity fund” for higher claims, factoring in the poverty level of the member.

Entering into reinsurance arrangements to allow for loss ratios above 100%.

This planned change in risk management strategy is aimed at building a more robust framework to demonstrate to IRDA, the insurance regulator, that the community-based mutual model is sustainable, without detracting from its core focus on communities. Such a recognition from the regulator would better enable Uplift to attract new NGO partners and to grow as an organization.

Identified risks include potential changes in claimant behavior after the introduction of the solidarity fund (e.g. members choosing private hospitals over public hospitals if they know they can make a claim from the solidarity fund), liquidity issues, and residual high claim costs.
This section analyzes the key performance indicators of the scheme.

4.1 Enrolments
Since 2003, the member base of the Uplift network has grown steadily, increasing 500% in four years, surging from 27,000 in 2007 to 162,911 in 2011. A significant contributor to this dramatic growth has been APVS Pune, whose member base registered a 155% increase in a single year, increasing from 14,152 (2007) to 36,170 (2008). In 2011, APVS had 66,128 members, accounting for almost 50% of Uplift’s total membership base. Similarly, the introduction of the program at APVS Mumbai in 2008 and at Chaitanya Pune in 2010 significantly increased the number of enrolments.

4.2 Renewal Ratio
A steady increase in aggregate renewal ratio\textsuperscript{13} for three member organizations can be observed in the period from 2006 to 2011. This growth is significant, as the increased number of enrolments since 2008 has also been accompanied by a rise in the renewal ratio. Notably, renewal ratios for APVS Pune and PSW have been similar since 2007, though membership for PSW was voluntary until 2010. As seen in Table 4, the renewal ratios of all partner organizations have been rising.

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|}
\hline
Year & APVS Pune & APVS Mumbai & PSW \\
\hline
2003 & 21\% & - & - \\
2004 & 0\% & - & 7\% \\
2005 & 43\% & - & 29\% \\
2006 & 37\% & - & 51\% \\
2007 & 53\% & - & 55\% \\
2008 & 55\% & - & 56\% \\
2009 & 49\% & 40\% & 58\% \\
2010 & 54\% & 39\% & 72\% \\
2011 & 66\% & 54\% & 71\% \\
\hline
\end{tabular}
\caption{Renewal Ratio Over Time}
\end{table}

The high renewal rates seen among some organizations of the Uplift network are rare, and may have valuable insights for all micro health insurance schemes aiming to achieve greater viability while maintaining client desirability.

\textsuperscript{13} Renewal ratio is the ratio of number of policies renewed in the final year to the total number of policies in initial year.
4.3 Utilization

This study considers claim frequency to be a measure for utilization\(^\text{14}\). Since 2008, the claim frequency has moved closer to the average national morbidity rate. While the number of claims has grown in line with the growth in overall membership, a more careful analysis shows that the rise can be attributed to the voluntary members.

4.4 Average Claim Amounts

The average claim amount for three major partner organizations is Rs. 3392.6 (USD 67.8). This is lower than the average claim amount

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\(^{14}\) Claim Frequency: Ratio of the number of claims in the given period to the total number of policies issued for the given period
Addressing the Value and Viability trade-off in health insurance

reported under RSBY (Rashtriya Swasthya Bima Yojana); which is Rs. 4480 (USD 89.6)\(^{15}\).

4.5 Rejection Ratio

The aggregate claims rejection numbers for APVS Pune, APVS Mumbai, Parvati and Chaitanya are presented in Table 6.

4.6 Reason for claims

The break-up of medical conditions for which members sought claims in the year 2011 is depicted in Figure 6. Claims against communicable diseases are responsible for 34% of the total number of claims.

This implies that there is a great need to promote preventive practices such as good sanitation and hygiene, which could reduce the transmission of these diseases, leading to reduced hospitalization and contributing to reduced claims and improved sustainability of the program.

---

We measure the impact of Uplift using KPIs to indicate to what degree the program is valued by its clients, and its ability to be replicated sustainably. Valuable learnings can be gleaned for the sector, to identify what the factors contributing to the high re-enrollment ratios as well as the low rejection ratios may be.

The following sections use three measures to understand the matter in greater depth: client desirability, program viability and scalability. Factors contributing to each measure are also studied, and the value presented by the Uplift model for national and global health microinsurance policy makers is summarized.

5.1 Client Desirability

For microinsurance providers, it’s a trade-off between maintaining affordability and offering more add-on benefits in order to improve the usage and desirability of the product. Uplift’s experience of high re-enrolment rates and low claim rejection ratios suggests that the package provides extra features which make it more attractive to clients.

The following sub-sections analyze specific features and benefits of the Uplift model in increasing client desirability.

**Reduction of Out-of-Pocket Expenditure**

(The section draws from data collected and analyzed by Uplift. The methodology used in calculating out-of-pocket expenditure is explained in Annexure II.)

According to a study undertaken by Uplift, out-of-pocket health expenditure among client households reduced from 65% of the total expenditure in 2008 to 49% in 2009.

Uplift attributes this reduction to, Increase in the sum assured, as shown in Figure 5, Discounts provided by networked healthcare providers (HCPs), as shown in Figure 6.

Figure 5 shows that in 2008, claim reimbursements accounted for only 35% of clients’ expenditure, while 65% was out-of-pocket expenditure. By 2009, the out-of-pocket expenditure of the household fell to 49% of the actual medical expenditure. This could be due to the improved coverage limits of the product.

Uplift invests significant resources in selecting and monitoring a network of 300 healthcare providers, and in negoti-
ating discounted prices. When members use the helpline, Uplift is able to guide them to the most cost-efficient healthcare provider. Figure 6 showcases the overall reduction in medical costs of 27% between 2008 and 2009, due to discounts resulting from networking as well as the break-up of improvement in claims payout percentages, due to improved coverage limits.

These two factors cumulatively have reduced the OOP burden on the household.

Enhancing Client Desirability

The role of other initiatives in adding value to the Arogya Nidhi program is discussed below:

Risk-reduction strategies such as health camps and discounts on diagnostic procedures substantially enhance client desirability. These services are also perceived to help in reducing the probability of hospitalization, hence reducing the claim burden on the program.

As Uplift’s member base typically has little prior experience with health insurance, considerable effort is directed towards creating awareness of the need for insurance within the communities. One important component is health-specific awareness campaigns, based on type of illness for which claims are made. Community-based strategic review of the operation of the program is leading to a sense of deeper ownership, and subsequently better servicing of the insurance needs of the communities.

Since the product is reimbursement-based and the immediate burden of hospital payment falls on the member, Uplift has experimented with offering an instant and interest-free cash loan to members at the time of hospitalization. This offering is currently being tested, to make the product more customer-friendly and mimic the efficiency of a cashless health insurance product.

Certain program features have the potential to negatively impact client desirability. These require detailed study to ameliorate these program limitations. As a reimbursement-based scheme, clients often have to avail emergency credit at usurious rates to make upfront payments to healthcare service providers. It has also been observed that the clients’ actual out-of-pocket expenditure for insured medical treatments is much higher than the amount they are entitled to be reimbursed under the scheme.

By design, the program encourages clients to seek treatment from public facilities.
and invests in support mechanisms to facilitate treatment there. It also dis-incentivizes the use of private clinics, through partial reimbursements for the treatment cost. This limits choices and inconveniences the household.

As is seen in other mutuals, Uplift is marked by high administrative cost, ranging from 37% to 52% among some of its partner organizations. Additionally, only 60% of the premium collected is allocated for claim settlement, which is considerably lower than in similar schemes serving low-income households.

The above observations suggest that there is need to increase the sum assured in a sustainable manner. A cashless system can also be explored, to avoid severe expenses at the time of hospitalization.

### 5.2 Sustainability and Reliability

This section analyzes the present and future sustainability options of the program, by evaluating product costs, operating expenses and the cost of risk-reduction services.

The program is funded through the collection of premiums and grants. Since program costs are not fully retrieved from the premium collections, it has not yet achieved sustainability. However, recent trends indicate a journey towards greater sustainability.

Program expenses are categorized under three heads. 60% is allocated to the

### Roadblocks in the journey to a cashless system

Uplift’s inability to roll out a cashless mechanism has insights for other mutuals. Inhibiting factors are:

- Healthcare providers would have to invest in technology which would on a rough estimate imply a price increase of 30-40%, effectively eroding the price benefits of negotiations with Uplift.
- The community claim decision-making process is compromised by the immediate cashless settlement system, increasing the risks of fraud.
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The costs for administration and service for Uplift is shown in the graph below (partner-specific break-up is available in Annexure I).

Towards Sustainability:

The costs for administration and service for Uplift is shown in the graph below (partner-specific break-up is available in Annexure I).

As can be seen from the above graph, overall costs have seen a decreasing trend, dependence on subsidy has reduced over the years (red), but operational cost has increased (blue) as against the service charge collected from members (green).

In order to turn the scheme into a fully self-sustaining model in the future, Uplift has taken the following steps:

- Automation of field activities such as enrolments, renewals and premium payments
- Exploration of availing reinsurance
- Setting a target of 70% renewals, as this implies an automatic reduction in client education cost and also a healthier pool

It may be noted that the reason for the higher operational expenses (ranging from 37% to 52%) is mostly due to the delivery of value-added healthcare services. This component of the program is supported by grants provided to partner organizations through Uplift’s partner, InterAide.

Table 7 outlines the break-up of various costs for the scheme, comparing the overheads of PSW and APVS. The actual product cost for APVS Pune is Rs. 129.1 (USD 2.6) per member, while the same for PSW is Rs. 159.5 (USD 3.2). The operational cost per member for PSW (Rs. 83.5 or USD 1.67) is significantly higher than that for APVS Pune (Rs. 48.3 or USD 0.96), which makes for the difference between their final product costs.
The methodology used for calculating product and operational costs is explained in Annexure I. The difference in costs between organizations is mainly due to volume. APVS Pune has the largest member base, and hence can spread the costs across a greater number of members.

Benefits from Networked Providers: Uplift’s internal tracker suggests that networking and negotiations may have resulted in a cost savings of 23% for Uplift in 2008, which further improved to 27% in 2009.

Table 7: Total Product Cost for 2009 (with estimated costs for November/December) (in rupees per member)

<table>
<thead>
<tr>
<th></th>
<th>APVS Pune</th>
<th>%</th>
<th>APVS Mumbai</th>
<th>%</th>
<th>PSW</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims</td>
<td>56.5</td>
<td>44%</td>
<td>60.4</td>
<td>42%</td>
<td>45</td>
<td>28%</td>
</tr>
<tr>
<td>NGO</td>
<td>9.4</td>
<td></td>
<td>11.7</td>
<td></td>
<td>16.1</td>
<td></td>
</tr>
<tr>
<td>Uplift</td>
<td>14.9</td>
<td></td>
<td>14.9</td>
<td></td>
<td>14.9</td>
<td></td>
</tr>
<tr>
<td>Total value-added services</td>
<td>24.3</td>
<td>19%</td>
<td>26.6</td>
<td>19%</td>
<td>31</td>
<td>19%</td>
</tr>
<tr>
<td>NGO</td>
<td>28.9</td>
<td></td>
<td>36.5</td>
<td></td>
<td>64</td>
<td></td>
</tr>
<tr>
<td>Uplift</td>
<td>19.5</td>
<td></td>
<td>19.5</td>
<td></td>
<td>19.5</td>
<td></td>
</tr>
<tr>
<td>Total operational cost</td>
<td>48.4</td>
<td>37%</td>
<td>55.9</td>
<td>39%</td>
<td>83.5</td>
<td>52%</td>
</tr>
<tr>
<td>Total product cost</td>
<td>129.1</td>
<td></td>
<td>142.9</td>
<td></td>
<td>159.5</td>
<td></td>
</tr>
</tbody>
</table>

While the Uplift partners have been working towards reducing their administrative cost, there is a marked increase in their claims rate. In addition, the high investment in community education; a key feature of mutual models, contributes further to increasing the operational cost. In future, the value-add services, which are presently funded through external grants, will have to be paid for internally.

Any further improvement on this account could contribute significantly to the goal of sustainability.

Claims Fund for Hospitalization Cover: With the awareness that mutuals have a higher administrative cost, Uplift allocates internal parameters such that only 60% of total premium collection is set aside for claims payment. The claims ratio is calculated not on the total premium collected, but on the 60% of the premium collections allocated towards claim settlement. Any funds...
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removing after the servicing of claims are maintained as a reserve.

From Figure 9, it is clear that claim ratios rise through the first few years to just over 100% in 2010, and hover just below 100% in 2011, for most of the implementing organizations.

The rise in the claims ratio can be attributed to the increased awareness and insurance literacy among clients, and the growing percentage of voluntarily insured clients in the portfolio. As membership expands, Uplift needs to maintain or reduce the ratio of voluntary enrolments in order to contain claims costs.

Expenses on Value-Added Healthcare Services for Members: Uplift provides a bouquet of services to reduce the health risk faced by communities. The cost per member for these risk-reduction services is presented in Table 8. From its 20% share of premium collected, Uplift TPA spends Rs. 14.9 (USD 0.3) per member on value-added services and Third Party Administrator (TPA) costs.

Table 8: Break-up of Costs per Member (in rupees) for Value-Added Healthcare Services

<table>
<thead>
<tr>
<th></th>
<th>2009 only (estimate for November and/or December)</th>
<th>Uplift</th>
<th>APVS Pune</th>
<th>APVS Mumbai</th>
<th>PSW</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP care (“OP beat”)</td>
<td></td>
<td>1.9</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>24x7 helpline</td>
<td></td>
<td>1.5</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Network HCP</td>
<td></td>
<td>2.4</td>
<td>0.7</td>
<td>0.9</td>
<td>1.1</td>
</tr>
<tr>
<td>Referrals/guidance (by SEs)</td>
<td></td>
<td>0</td>
<td>2.4</td>
<td>2.4</td>
<td>5.4</td>
</tr>
<tr>
<td>Health camp</td>
<td></td>
<td>1.3</td>
<td>0.5</td>
<td>0.8</td>
<td>0.8</td>
</tr>
<tr>
<td>Health talks</td>
<td></td>
<td>0.4</td>
<td>0</td>
<td>0</td>
<td>1.5</td>
</tr>
<tr>
<td>Client education</td>
<td></td>
<td>0.2</td>
<td>1.1</td>
<td>1.5</td>
<td>0</td>
</tr>
<tr>
<td>TPA</td>
<td></td>
<td>7.1</td>
<td>4.8</td>
<td>6.1</td>
<td>7.3</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>14.9</td>
<td>9.4</td>
<td>11.7</td>
<td>16.1</td>
</tr>
</tbody>
</table>

Table 9: Change in Service and Administration Expenses

<table>
<thead>
<tr>
<th></th>
<th>Service and administration expenses per member in 2008 (in rupees)</th>
<th>Service and administration expenses per member in 2009 (in rupees)</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uplift</td>
<td>45.5</td>
<td>31.2</td>
<td>-31%</td>
</tr>
<tr>
<td>APVS Pune</td>
<td>73.6</td>
<td>57.6</td>
<td>-21%</td>
</tr>
<tr>
<td>PSW</td>
<td>93.7</td>
<td>107.9</td>
<td>15%</td>
</tr>
</tbody>
</table>

TPA costs are the highest, accounting for approximately 50% of total costs, and include claim checking by medical professionals, related operational costs, and monitoring and evaluation of networked hospitals.

Operational Expenses: Table 9 shows the change in administrative expenses from 2008 to 2009, using data on service and administrative expenses.

The claim ratios for APVS Pune went up by 36%, while administration expenses dropped by 21%. On the other hand, claim ratios for PSW fell by 13% with a subsequent rise of 15% in administration expenses. The increase in costs is primarily due to increased costs of staff. This is distributed over a larger client base in the case of APVS Pune than in the case of PSW.

Sustainability is a key goal for Uplift, and based on past experience, further operational efficiencies and sustained increase in membership may be required to achieve it.
Uplift is a crucial player in the health insurance space, presenting a more comprehensive and community-involved model. Features with high client desirability such as reduction in out-of-pocket health expenditure, very low rejection rates and transparency in the claims settlement process has led to a rare case of high voluntary re-enrollment in microinsurance. Additionally, the provision of out-patient health services along with in-patient care financing has the potential to demonstrate a valuable model of cost containment to the sector. Uplift’s special focus on ensuring inclusion of the poorest families in the program also offers valuable insights for the sector.

Uplift is currently going through a growth phase, and is exploring the paths to self-sustainability through operational efficiency, reduction in product costs, and scale.

The following are some key recommendations to Uplift and its replicators on how to achieve sustainable growth:

**Growth with the ‘right’ partners:** Partnerships should be forged with new organizations with a reasonable membership and shared institutional philosophy. Partner selection should also be based on the partner’s operational cost.

**Law of large numbers:** Compulsory membership has contributed large numbers to the risk pool and reduces adverse selection. Uplift will have to maintain the ratio of compulsory membership to achieve faster sustainability.

**Continuity is key:** A recent surge in membership has meant higher workloads for the Arogya Sakhis, possibly a leading cause for their higher attrition rate. It is critical to improve retention of Arogya Sakhis to maintain program health and service quality.

**Automation in the field:** The automation of some field functions, documentation and reporting, to increase the efficiency of ground staff and to streamline field processes, is a step in the right direction and may contribute to improved sustainability and may also improve staff retention. It may also be worthwhile to consider greater staff and resource allocation to operational leaders, to enable them to better represent the organization, ensure proper marketing of services, and ultimately to forge better partnerships.

**Exporting the risk:** Uplift is implementing a range of process changes to improve its risk management model. These steps include establishing a “solidarity fund” for higher reimbursement against large claims, based on the poverty level of the member; entering into reinsurance arrangements to allow for full reimbursements above the earned premium (i.e., to allow for loss ratios above 100%); and pooling funds at the central level (funds were earlier pooled at the NGO level) to improve its services.

**Spreading the net further:** It may be important to look at the possibility of designing a benefit package with a higher financial coverage limit, which may become possible once the facility for reinsurance is in place.
Uplift has achieved a sustained increase in renewals (see Section 5) and a falling rejection ratio; key goals for micro health insurance programs.

The program has experienced mixed success in implementing the health mutual model; while the model has high development impact, it is yet to achieve financial sustainability.

As an active member of microinsurance exchange and interaction forums like the Community-Led Association for Social Security Initiative and the Global Information on Microinsurance portal, Uplift contributes to learning and knowledge sharing within the sector. Its programmatic data can help evaluate the possible impact of value-added medical services on the health stock and spearhead delivery of more comprehensive healthcare models.

In the context of universal access to healthcare in developing countries, the Uplift model offers key insights for other mutuals, health insurance delivery agencies and policy makers.

**Learnings for Practitioners**

Listed below are some key operational components of the Uplift program, relevant for practitioners.

**Enhanced client value:** For the success of a microinsurance scheme, the insurance cover needs to be supplemented. This is in response to the need for ‘tangible’ outputs in non-claim years. Uplift's additional package of healthcare services has enhanced client perception of the value of the program, and enabled greater renewals.

**Delivery model:** The Arogya Sakhi is a crucial interface, responsible for service delivery while leveraging the community and available partner organization resources. They support the community and the overall management, improving the value proposition of the health mutual.

**Institutional philosophy:** Uplift’s philosophy is to leverage community solidarity to harness the social capital, to employ mutual pooling as a strategy to manage health risks, and to ensure community ownership. Uplift’s health mutuals program allows for a sustained role in its critical functions and operations.

**Standardization:** Uplift has standardized most of its delivery processes into manuals to improve efficiency. Delays in claims processing, renewals, and other critical components of the process have thus reduced. This also allows for ease in expansion and replicability. This has been necessary because of the model's dependence on semi-literate community members for core decision making.

**Replicability:** The manualization of processes, together with an information management system, has ensured Uplift’s readiness for replication and ability to operate through a franchise model. This also insulates the organization from staff attrition.
The methodology and data used for this analysis are:

- Data of paid expenses for the years 2008 and 2009
- Details of subsidies supporting each organization
- Average number of active members for each year, to determine the cost per member
- Apportioning of staff time to the identified member services

Partner-specific service and administrative costs are presented below.

For APVS Pune, overall costs and dependence on subsidy have both fallen (red) and operational cost (blue) is lower in 2009 than it was in 2008. The sustainability ratio compares expenses to an administration and service fee (shown in green) of Rs. 40 (USD 0.8) per member.

Unlike other organizations, costs for PSW actually increased in 2009. For PSW, certain members were exempted from bearing the administration and service fee, based on their poverty level. This reflects in lower collections of service fee.
Uplift initiated client-level data collection to measure its impact on the client’s out-of-pocket expenditure. Benefits are calculated on two lines:

**Concession:** The difference between the rates offered by the network provider as part of its MoU with Uplift, and the standard market rates of the provider for the same service. Rates are stipulated as either a percentage/rupee discount, or a specific rate is set for each service. This benefit is easy to measure.

**Amount saved:** The difference in rates charged by the network provider and Uplift’s knowledge of the rates generally charged by other hospitals for the same treatment. This discount cannot be calculated as precisely.

The analysis has been performed for settled claims. The annual claims settlement data for each NGO from 2007 to 2009 was examined to identify the cost reductions generated for the claims fund.

**Results:** The total effect of Uplift’s network of providers is shown below on a per member basis, for ease of comparison to the Rs. 60 (USD 1.2) contribution of each member to the claim fund.

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**Figure 12:** Impact of Network HCP on Settled Claims (rupee per member)

**Figure 13:** Impact of networked HCP on settled claims (Rupees per member)