A LITER OF MILK:
Right Doctor, Right Treatment, Right Cost: Service Value and Perceived Value at UPLIFT India Association[1]

Executive Summary

Uplift India Association is a mutual-based, community-managed health microinsurance program serving poor and low-income families living in the slums of Pune and Mumbai, India. The program combines its core hospitalization coverage (paid on a reimbursement basis) with a wide range of additional benefits, including discounts on outpatient care and drugs, health promotion and preventive care activities, and a 24/7 telephone helpline and referral services. An earlier study (McGuinness, 2011) found substantial financial value in the program for clients who used the hospitalization benefit, but only 2% of members use that benefit per year. This study seeks to understand the value, including the service value, gleaned from the product by *all* members, including those who do not make hospitalization claims. It also seeks insight into client perceptions of value in the many components of the product. Data was collected through focus group discussions with members and non-members of the program and interviews with staff of Uplift and partner institutions.

We find that the hospitalization benefit is critical to perceived value. Even members who do not use this benefit perceive it as important for the peace of mind it brings. Discounts were ranked as lower value on average by respondents, some of whom reported that discounts were available without insurance. The insured perceived higher value in these discounts, perhaps an indication that the product is targeting and benefitting those individuals who lack the ability to negotiate discounts on their own. Referrals and a 24/7 telephone helpline were seen as crucial to accessing the other benefits of the program by providing important information and facilitating admissions. Respondents expressed a wide range of views about the value of outpatient benefits, some of which were not well known.

The program increases access to quality healthcare by reducing both financial and non-financial barriers. The discounts and hospitalization coverage make seeking care more affordable than if would otherwise be, especially at private hospitals. At the same time, other components of the program help members to overcome non-financial barriers by providing information and guidance and facilitating the process of seeking care.

Though members perceive very different levels of value in the various services and some services are used very infrequently, members are very resistant to giving up any of them, perhaps demonstrating that "the whole is greater than the sum of the parts," and that clients perceive intangible benefits in even those components of the product that are intended to provide a tangible experience with the product.

[1] This brief was written by Elizabeth McGuinness a guest contributor to the MicroInsurance Centre's MILK project (November 2013).

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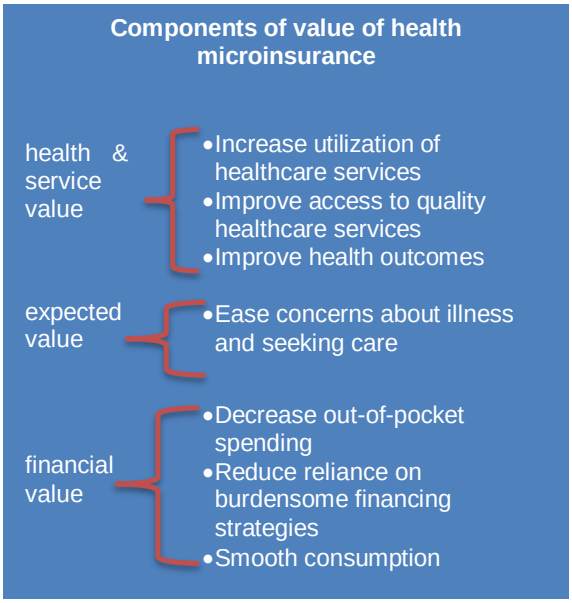
Introduction[2]

Uplift India Association (Uplift) is a mutual-based, community-managed health insurance program serving poor and low-income families living in the slums of Pune and Mumbai, India. The program combines its core hospitalization coverage (paid on a reimbursement basis) with a wide range of additional benefits. Only 2% of HMF members will submit a claim for reimbursement within a given year, signifying that only a small share of policyholders obtain any significant financial value from the program. Recognizing this, Uplift designed the health microinsurance model so that everyone paying a premium had the possibility of getting some tangible benefit.

> *"We are worried about the 98 remaining people who will not have any value if they don't get a claim." (D. Kulkarni, Interview, February 2011)*

The Uplift model, considered the "flagship" mutual health insurance program in India, combines active member involvement in insurance product and process decisions with product benefits that range from in-patient care to health education. This model raises interesting questions about the degree to which the program provides value to policyholders and if so, how. A previous study (McGuinness, 2011) found that the program does provide substantial financial value to members who use its core hospitalization benefit. The purpose of this paper is to explore the other types of client value that this program may have for members, notably through service value (access to and utilization of quality healthcare services) and expected value (peace of mind). It also explores the value members *perceive* in different elements of the program. In contrast the MicroInsurance Centre's MILK client math studies, which document spending, financing, and other client behaviors, this brief focuses on members' perspectives on the insurance and non-insurance elements of the program.



The author conducted qualitative research at Uplift India Association in 2011 to investigate the value of the program for the members. An earlier paper examined whether Uplift's Health Mutual Fund (HMF) product protected families financially, and if so, how the community-managed reimbursement process affected the level of financial protection afforded to members (McGuinness, 2011). Through interviews with insured and uninsured households which had experienced a serious case of malaria, the study found that HMF families had lower average out-of-pocket medical costs than the uninsured both before (USD 272 vs. USD 422) and after (USD 182 vs. USD 422) receiving insurance payouts.

An analysis of key institutional performance indicators for the year 2010 revealed that Uplift provides substantial value to policyholders at the institutional level, within the constraints of a low premium price. Uplift sets aside 60% of premiums for claims payouts and the remaining 40% is used to cover operating costs. The incurred claims ratio was 63%, demonstrating that the program paid out 3% more in claims than it had set aside as earned premiums in that year. The claims rejection ratio was 4.6%, evidence that almost all of the policyholders who submit claims are receiving a payment. The social investment ratio was 14% at Uplift and 3% respectively for each of the partners, demonstrating the share of expenses devoted to non-insurance services.

[2] The author would like to thank Walter Tounytsky, Anuprita Dixit and Sunil Bhat who contributed to data collection, analysis and portions of this report. Additional thanks to Jessica Bachay and Amna Kanoun for their support with analysis and report production. Thanks are also due to Michael McCord and Barbara Magnoni who provided input to the study design. Special thanks are due to local consultants in Pune who assisted with this research, specifically Anuprita Dixit who worked tirelessly to organize the focus group discussions and Vandana Apte who provided interpretation to the field researchers. Finally this report would not be possible without the support of Uplift India Association, and its microcredit partners, APVS and PSW.

At the same time, Uplift strives to balance client value with financial sustainability. MILK's study of the business case for health microinsurance in India (Koven et al., 2013) revealed that Uplift's program is quite close to financial sustainability (showing a loss of only USD 0.11 per member in 2011, before donor subsidy is accounted for), while other private programs struggle more. As it is at the brink of achieving financial sustainability and its donor subsidy has recently expired, Uplift must consider the difficult tradeoffs involved in improving or even maintaining client value while keeping costs in check. Uplift's clients are highly price sensitive; they are generally poor or near poor, with 20% having incomes that fall below the national poverty line, making an increase in premiums difficult. As such, a clear understanding of where Uplift's clients obtain value from the product and where they perceive value can inform its efforts to achieve this balance between value and sustainability moving forward.

In this report, the question of client value is examined in greater depth, including the concepts of *expected value* - the value arising from behavioral incentives and peace of mind, even if claims are not made - and *service quality value* - the externalities and value created by providing access to product-related services of benefit to the client. Using the results of qualitative interviews with HMF members and others, this paper explores client perceptions of the value of the HMF program. The study examines which HMF service components are valued by clients and why, and delves into qualitative aspects of increasing access to and utilization of health services.

Background on the HMF

In Uplift's mutual model, policyholders are actively engaged in managing some of the key features of the product and its implementation. They hold decision-making power over insurance premium rates, network healthcare providers, claims approvals and reimbursement amounts. The program has continually evolved since 2003 as it tries to balance client preferences with the need for financial viability.

The Health Mutual Fund (HMF), as the Uplift program is known, provides cover for in-patient treatment within a large hospital network on a reimbursement basis. This insurance feature is complemented with health promotion services such as access to lower cost outpatient care, medicines and medical tests, as well as health education, health camps and referrals.

The benefits available to Uplift members include:

- low cost or discounted in-patient treatment at 173 network hospitals including government, private and trust hospitals;
- reimbursement of 50-100% of claimable hospital costs; and
- price discounts at network out-patient doctors, drug stores, and labs.

Product and additional services

Uplift has put in place a number of other features – including a guidance doctor, health education talks, and access to free screening, diagnostic and health services – to promote better preventive health and health seeking behavior among members. These complementary, non-insurance components of the HMF are designed to provide tangible services to members as well as to improve members' health and thus reduce pressure on the claims fund. Table 1 provides a summary of product details.

Table 1 Description of Uplift's Health Microinsurance Product[3]

Payment Type:	Reimbursement
Eligibility Criteria:	-Policyholders should be above 18 years of age -Family membership requires two adults and at least two children -Adults without children, dependent parents, and siblings are considered as individuals
Premium Contribution:	-Individual membership: USD 3.33 per person per year -Family membership: USD 2.22 per person per year
Period of Cover:	12 months
Maximum cover:	Up to USD 333.33 per person per year

[3] Product details as of the time of study, Dec 2011.

Benefits Offered:	-In-patient hospitalization expenses for treatment in general ward -10 days of pre- and post-hospitalization cover, including expenses for one time diagnosis of the ailment and the cost of prescriptions during this period
Coverage Limits According to Healthcare Providers:	-100% reimbursement for treatment at government hospitals -50% reimbursement for treatment at private or Trust network hospitals -0% reimbursement for treatment at non-network private hospitals except in cases of emergency.
Exclusions:	-Various exclusions apply -Pre-existing conditions covered from the 3rd year of membership
Additional benefits & member services:	-Referral service -Preventive care -Guidance doctor -Discounts for outpatient care, drugs and lab services -24/7 Telephone Helpline staffed by a doctor -Provision of a multi-layered quality healthcare network -Health promotion activities

Implementing partners

The HMF insurance is delivered primarily through integration with microcredit programs in which the insurance is compulsory for all borrowers.[4] This delivery model lowers transactions costs for both Uplift and the policyholders, while the mandatory nature of the product increases the risk pool and reduces the chances of adverse selection. As of October 2011, there were 121,915 insured HMF members across Maharashtra state.[5]

Uplift has two microcredit implementing partners in Pune (the location of this study): Parvati Swayamrajgar (PSW) and Annapurna Parivar Vikas Samvardhan (APVS) with 18,000 and 54,461 HMF members, respectively. These partners are responsible for promoting the health microinsurance program, enrolling members, collecting premiums, some processing of claims documents, and disbursing claims payments. They also implement the health management activities, such as health talks and health camps, and provide space for the Guidance Doctor. A dedicated Service Executive (SE) works at each NGO branch office to manage the HMF program in that area. PSW has seven branch offices and APVS has eight within the city of Pune. (See Appendix 1 for more information on the partners).

Methodology and Respondents

The research was carried out through focus group discussions (FGDs) with HMF members and other community members as well as through individual interviews with key informants at Uplift and partner institutions. Appendix 2 provides a full description of the methodology used. FGD participants came from established slum communities within Pune. The FGD sample included HMF members who have submitted a claim, HMF members who have not, former HMF members and non-HMF individuals.

Generally, the participants live in difficult economic conditions and have low levels of education and awareness of health issues. The majority of FGD participants were women (76%) and the average age of participants was 38. About 94% of male respondents and 75% of female participants were literate. The Non-HMF women were more likely to be literate than the HMF-Claimant women but the male Non-HMF participants were less literate than the other male participants.

Many of the women participants work as housemaids while men work in construction or as casual laborers. Self-employed participants typically managed small businesses, such a vegetable or food vending, home tailoring, and auto-rickshaw operations. Better paid, permanent jobs were rare among the participants. All male respondents reported having worked in the past year while only two-thirds of women reported the same.

[4] At PSW, one of Uplift's partners, borrowers are not required to purchase HMF coverage provided they can prove they are covered by another health insurance policy.
[5] D. Kulkarni, personal communication, December 19, 2011.

The communities in which the FGD respondents live include a range of socio-economic groups, including poor, middle income and rich households. Between 10 to 30% of the population was reported to be "poor;" 50 to 60% were reported as "middle" income, while 10 to 40% are considered as "rich." Poor households were said to earn between INR 1,000 to 2,000 (USD 16.66 to 33.33)[6] per month while middle-income families earn from INR 4,000 to 5,000 (USD 66.66 to 83.33) and rich households make more than INR 7,000 (USD 116.66) on average per month. Only poor and middle-income households reportedly join APVS and PSW, further indicating that the HMF members straddle the poverty line. See Appendices 3 - 5 for more information on the participant sample.

Findings

HMF member perceptions of program value

The research explored the value of different components of the HMF product as perceived by sampled HMF members and former members. The FGD participants were asked to:

1. identify all the services of the HMF program;
2. rank each service according to importance;
3. discuss what factors were important in their decision to buy the insurance, and;
4. select which one of the HMF services they would eliminate if one service had to be dropped.

The purpose of this exercise was to understand how and why members perceive value in each of the non-insurance services offered by HMF, both in absolute terms and in relation to other financial and non-financial components of the program.

Claim benefit

The claim benefit was critical to perceived value; across all three HMF sample groups, the insurance benefit was ranked first, suggesting that financial concerns dominate perception of HMF value for members and ex-members alike (see Figure 1 below). Benefits were perceived to cover a sizeable amount of members' hospital bills (40% and 100% of the direct costs of hospital care). As one participant put it,

> *"It was a great relief getting money back." (Female, PSW, HMF Claimant)*

Even groups of members who had not filed claims ranked the claim benefit first. While they recognized the potential value for themselves and their families, they also recognized that the HMF (as a risk pooling mechanism) benefits others:

> *"Even if I don't use it, someone else does. It assists the needy at the right time." (Female, PSW, HMF Non-Claimant)*

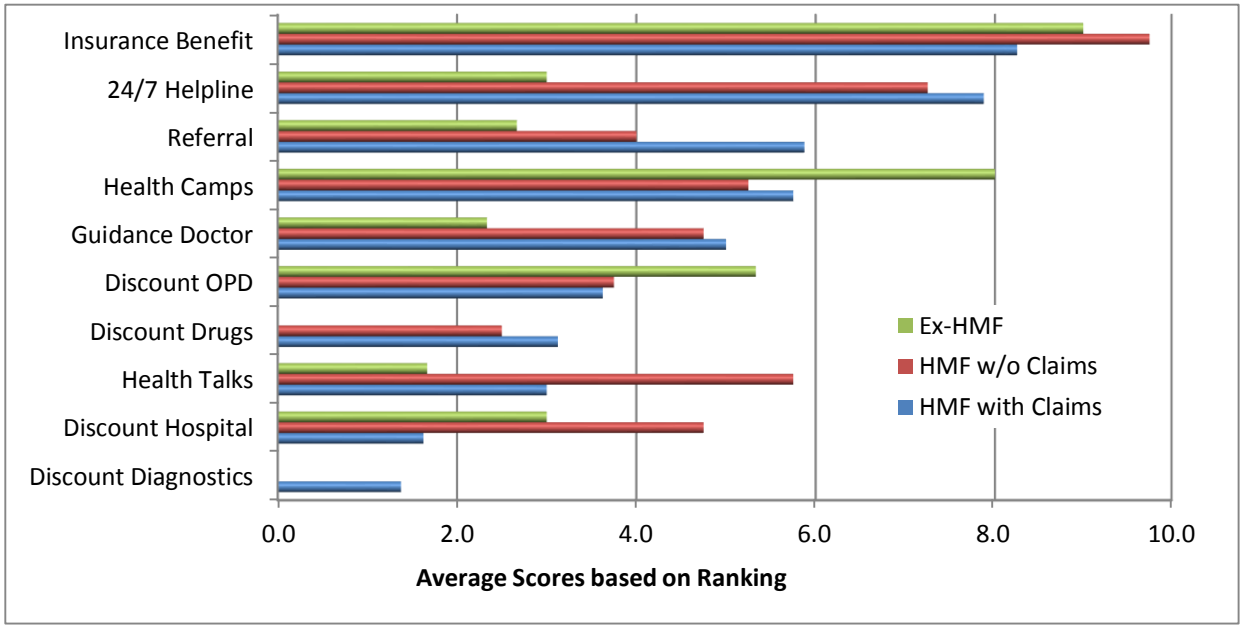
This suggests that in addition to financial value, the HMF provides *expected value* for members who purchase but don't use the insurance, in terms of peace of mind. This finding echoes that of MILK's experimental study of demand for a life microinsurance product in Mexico (Bauchet et al., 2012). That study found that women covered by the life microinsurance product that they were very unlikely to make a claim on perceived great value in the peace of mind it brought, and also showed willingness to pay to retain their coverage when a subsidy was removed.

While it may come as no surprise that cash benefits were ranked first, it was interesting to find that one of the HMF Claimant groups ranked this feature fairly low, pulling down the average score for this component. Participants in this group complained that they did not understand why the claims payout could vary from 50% to 80% of the amount submitted. This expressed uncertainty may have been aggravated by the fact that many policyholders borrow money to pay for hospital care, relying on reimbursement funds to repay their loans. Indeed, several of MILK's Client Math studies find that insured households may leverage the expectation of an insurance payout to access loans from friends and family; delay or uncertainty about insurance payouts can lead to further stress and strain these relationships. The claims reimbursement facility was also criticized by other HMF Claimants for not covering common or chronic illnesses such as high blood pressure or diabetes. These two issues are areas in which better

[6] Using an exchange rate of INR 60 = USD 1.00.

communication and information sharing with members could improve product understanding and manage policyholder expectations, and thereby increase both the perceived value of the product by those who make claims and their ability to use the product effectively.

Figure 1. Member ranking of the importance of HMF services by sample segment



Calculation method: Each component was assigned a value based on the ranking position (i.e. a ranking of one was assigned 10 points). Scores were combined for all FGDs of each sample segment. The average score was calculated based on the number of FGDs that took part in the ranking exercise.

Hospital discounts

Private, in-network hospitals provide discounts to HMF members based on rates negotiated with Uplift. The discounts on hospital costs were reported by participants to include reductions of up to 50% on doctor's fees. Presentation of the HMF card (Nidhi card) upon arrival at private network hospitals also allowed members to avoid depositing an advance payment in order to be admitted.

Hospital discounts were ranked in the middle of all HMF features but were specifically discussed by only a few FGD groups. The discounts provide direct financial value to members who use hospitals. Participants who mentioned the discounts were well aware of this facility. The doctor on the 24/7 Helpline and the SE remind members to inquire about the discount should they not be offered it automatically.

Significantly, participants mentioned that receiving the discount through the HMF does not require negotiations. This is important because many HMF members might be unlikely to negotiate discounts for themselves. They may lack the confidence or the clout to do so, whereas Uplift can play an important role in negotiating group discounts and advocating for members.

Discount out-patient care, drugs and diagnostic services

Membership in HMF entitles participants to discounts on out-patient doctors (OPDs), medicines and diagnostic services. Network practitioners and pharmacists offer discounts of varying amounts. In-network OPDs offer discounts of up to 20%; discounts for medicine at affiliated pharmacies range from 7% to 15%. To redeem the discount, members have to produce their Nidhi card when visiting these doctors and pharmacies.

Participants in the FGDs ranked the discounted services separately, but we discuss them together here. Overall, discounted OPDs were more highly valued than discounted drugs or diagnostic services, which were ranked last and next to last, respectively, of all HMF features. This may be because not all FGD groups were aware of these services. Additionally, discounts on prescription drug costs were not well regarded by some groups, as they could be obtained only at particular pharmacies.

Discounts on OPD consultations were more likely to be identified as an HMF service by FGD participants; however, opinions about these varied. OPD costs are generally low: participants mentioned costs from INR 40 to as high as INR 500 (USD 0.66 – USD 8.33), and the discount is usually about 10%. The value of this service increases when a member uses OPD quite frequently. For example, women with young children especially appreciated saving money by using a network OPD. In cases when a member deals with a minor illness requiring a one-time visit there is a perception that this service is not of much value because the amount saved is "a paltry sum," as one Ex-HMF member put it. The small size of the discount means that, although it may provide financial relief that is important to some (especially the poorest or those who use it more frequently), it is unlikely on its own to substantially increase access to care or incentivize utilization of services, as more comprehensive coverage can (see MILK Brief #12).

Some Ex-HMF members were of the opinion that one can get discounts on OPD bills without being insured through the HMF:

> *"A doctor will give a discount if you ask for it. To say we get discounts because of HMF is futile." (Female, PSW, Ex-HMF)*

However, the majority of respondents did not mention this option and did not report having tried to negotiate a discount on their own. Discounts may be available to those who are willing to bargain and even those who are not. One OPD reported to us that she gave discounts to about 20% to 30% of her patients depending on their economic condition and not on whether they requested a price break. Uplift's value, therefore, may not be that it can access group discounts as much as that it serves as a negotiator on behalf of its members who may not be sufficiently empowered to assert themselves with doctors.

Finally, there were some negative perceptions among FGD participants that the OPD network is used by doctors to generate business for certain hospitals:

> *"The OPD doctor gives a referral chit [i.e. written referral] for further treatment. They ask us to go to private hospitals. We do not have capacity to pay that much." (Female, PSW, Ex-HMF)*

These fears are not unfounded, as a key informant at Uplift explained that the health care system in Pune is run on the "cut system." That is, doctors make commissions from referring patients to specific hospitals, pharmacies and even diagnostic centers.

The above discussion highlights that HMF members' perceptions differ from those of the non-members. For example, HMF members appreciated the ability to obtain price discounts through Uplift whereas non-members thought they could obtain discounts on their own. This suggests that the HMF may be targeting a segment of the customer market that, perhaps due to its lower socioeconomic status, tends to lack the empowerment, confidence and negotiating skills to advocate on their own behalf. The findings also suggest that being an advocate for policyholders at this socio-economic level may help attract and retain those customers who feel less empowered.

Referrals

Uplift provides several options for members to obtain referrals when seeking healthcare. All referrals are recommendations to specific hospitals and can be obtained from the 24/7 Helpline, the branch SE or the Guidance Doctor. These three services (ranked 2nd, 3rd and 5th respectively by FGD participants) are discussed in more detail below.

The rules at Uplift regarding referrals have evolved over time. Currently, policyholders can go directly to the hospital and call to inform Uplift upon their arrival. If the member calls Uplift or the MFI in advance for the referral, then the staff person will call the hospital to alert them that an HMF patient is on her way.

The purpose of the referral is to hold down health care costs for the member and to ensure that she receives appropriate and quality care through guidance to the most suitable healthcare providers. When the HMF member contacts Uplift or the SE, she is informed of the locations and estimated costs of up to three types of hospitals (i.e. government, trust and private).

Generally, the FGD participants regarded referrals as a necessary condition for accessing medical treatment and maintaining eligibility for a claims payout. They perceived both financial value and service

value in this component of the coverage. Using a referral ensures that policyholders seek treatment at authorized (in-network or government) health care providers, so they know they will be eligible for reimbursement. Some of the FGD participants believe that a referral is necessary in order to get reimbursed. In fact, claims payouts are reduced but not eliminated for policyholders who do not get a referral. However, referrals are also helpful in obtaining discounts on hospital bills at private, in-network hospitals:

> *"Without the referral chit, we are not entitled to any of the discounts in the hospitals." (Male, PSW, HMF Claimant)*

One of the main areas of value conferred by the referral service came in the form of information about how to obtain appropriate treatment during emergency situations.

> *"It helps the members know where to go during times of emergency. If the referral is done right, than all other services happen properly." (Female, APVS, HMF Claimant)*

A second area of value involved the ability to save time and money.

> *"If they did not have access to a referral service in times of emergencies they would spend time searching for the right place and right doctor." (Female, PSW, HMF Claimant)*

The HMF referral system also allows members to save money through waivers of advance payments. Without the referral *"we would have to pay an advance deposit." (Female, PSW, HMF Non-Claimant)*

Finally, participants mentioned that referrals allowed them to access quality treatment in a timely way. Use of a referral from Uplift also helps smooth the way in the hospital.

> *"Entry into the hospital becomes very easy. We get faster service also." (Female, PSW, Non-Claimant)*

Members do recognize that they have a number of options regarding referrals. In addition, they can also look up the names and addresses of nearby hospitals on their insurance (Nidhi) card and go directly to the hospital themselves.

The referral feature appears to be a source of many types of value: financial value from saving on the initial deposit and associated financing costs, saving on the searching costs of finding an appropriate hospital, and allowing patients to be steered to a lower cost hospital. Service value is created by allowing policyholders to save search time, to obtain treatment in a more timely way, to access quality treatment and to obtain better customer care at the hospital. Both claimants and non-claimants alike recognize these types of value in the product, although they only experience them when they are used. This suggests that the referral service may have additional expected value in creating peace of mind among members: they know that they will have access to this resource at the particularly vulnerable time when they or a family member urgently need medical care.

24/7 Helpline

This service provides members with phone access 24 hours per day, 7 days per week to an Uplift doctor who can provide advice on health issues and guidance on seeking medical treatment. Members typically call for either general health advice or for assistance with claims. The 24/7 telephone number is printed on the insurance card, along with that of the SE, who also provides referrals.

Current HMF members value the 24/7 Helpline highly, and ranked it second after claims benefits. It was ranked lower on average by Ex-HMF groups, although some of these members were not aware of the service.

The importance of the 24/7 Helpline derives from the fact that it is available at any time of the day or night. Policyholders appreciate that they can access this service in times of stress:

"…Wherever there is an accident, all the members of the family are in fear and anxiety. We don't understand where to go. During such times this service is very useful…" (Female, APVS, HMF Non-Claimant)

"It becomes easy to make a decision if we get guidance in case of emergency." (Male, PSW, HMF Claimant)

One group mentioned that in cases of accident, people do not even think about the claim – instead, getting admitted to a hospital is what counts, demonstrating the critical role that referrals from the 24/7 Helpline play.

Participants in a number of FGDs mentioned that through the 24/7 Helpline they could be guided to the "right hospital." This is important as they can save money and get to the "right doctors." Participants stated that getting information about hospitals was important and valuable and that "this information is not available anywhere else." The terms "right hospital" and "right doctors" came up in several FGDs. The common use of terminology across a number of groups was striking. In the initial market research when Uplift was being formed, the founders learned that what clients really wanted was information. Specifically, they wanted to know: *Who is the right doctor? What is the right treatment? And what is the right cost? (S. Kumar, Interview, February 2011).* FGD participant feedback suggests that members are getting this information through the 24/7 Helpline and other referral services.

For respondents, the "right doctor" means a provider at which the treatment cost is reduced, the quality of treatment is not compromised and at which the HMF policyholder is eligible for cost reimbursement. Uplift ensures quality healthcare treatment by performing due diligence on all healthcare providers in the network. This involves reviewing hospital infrastructure, services and certifications as well as the qualifications of the medical staff. This is especially valuable for the poor, who are often taken advantage of by medical providers who over-treat for financial gain. As one Non-HMF participant put it when discussing private healthcare providers:

"They have all become like businessmen. These are big thefts. It is same like politics."

Additionally, dealing with hospitals and doctors is often intimidating for low-income people who are socially excluded and often looked down upon. Having a dedicated doctor on the other end of the 24/7 line who is qualified and respectful, is very important to them:

"The doctor talks well to us. He always has time for us."

It is very important to members that they talk to people they trust and know. As a result, they do not feel alone in times of difficulty.

Responses about the 24/7 Helpline mirror some of the perceptions of value in Uplift's discount and referral benefits. They offer another channel through which Uplift can advocate for the HMF members ensuring that they get the attention and proper medical treatment that they need. In the members' perceptions, the 24/7 Helpline is very important in helping them get through the process of seeking and obtaining health services:

"Once we get this service – the other things happen smoothly." (Female, APVS, Ex-HMF)

Support from the 24/7 Helpline and from other referral services at Uplift empowers members to be more assertive in dealing with hospitals and healthcare providers, which in turn allows them to obtain higher quality services faster:

"If they [doctors and hospital staff] give us bad treatment they will be asked by PSW people." (Male, PSW, HMF Claimant)

This again suggests that the Uplift program may have more value for segments of the population that are not empowered enough to make demands for better service or to ask for discounts by themselves.

Uplift's 24/7 Helpline and other referral services offer value to the institution as well as the clients. While the 24/7 Helpline and other referral options at Uplift represent expenses for Uplift, they steer policyholders to lower cost yet appropriate healthcare providers, which in turn keeps claims costs under control.

Health camps

Health camps are mobile health care services provided free of charge by local hospitals. Services include check-ups, preventive care and diagnostic services designed to address major health issues relevant to HMF members. Examples of camps held include: eye testing and cataract diagnosis, gynecological treatment, dentistry, bone density testing and ENT treatment. The health camps are coordinated by the SE and promoted well in advance. The camps are usually held on workdays at branches or in the members' communities. If specialized equipment is required, health camps are held at hospitals. Camps are reported to be held every two to three months in some areas.

Health camps received high average scores in the ranking exercise, but a closer examination of the results shows that these scores were inflated by high levels of awareness of health camps. Health camps were listed in more of the ranking exercises than other non-financial services, yet they were often ranked low in terms of value provided.

Across all groups, FGD participants were most familiar with eye camps, because these are quite common. Members can get free or low-cost eyeglasses as well as free cataract surgery through these camps. Participants also mentioned that they could get free annual check-ups at health camps.

> *"Health camps are good because they are free of cost. Additionally, it helps to diagnose diseases in the future." (Male PSW HMF Claimant)*

A number of respondents perceived health camps to provide little value because of problems with accessibility, availability and relevance. Some participants mentioned that the health camps took place only on workdays when they could not attend. They would find them more valuable if they took place on Sunday when working members were available.

> *"All women work in the area; hence we don't find time to attend it." (Female APVS HMF Claimant)*

Those who did see value them noted the importance of health camps for preventive health care:

> *"[Health] camps play a preventive role in disease management. We can do early diagnosis through camps… Accordingly I can change my habits or take preventive measures." (Male PSW HMF Claimant)*

Some groups had cynical attitudes toward the camps:

> *"The doctor only checks us and refers us to some hospital." (Female APVS HMF Claimant)*

> *"It is just an advertisement for the doctor." (Female, PSW Ex-HMF)*

Finally, one group mentioned that health camps are not unique to Uplift. Community members can also access health camps that are organized by youth groups or political parties.

However, other participants recognized that health camps are important for the poor in their community:

> *"Even if health camps are not utilized by many, those who are poor and cannot pay, go to the camps and get benefit out of it. There are people who use it." (Female APVS member, HMF Claimant)*

Guidance Doctor

Slightly over half of all FGD groups included the Guidance Doctor in their rankings of HMF services, demonstrating a lower level of awareness of this service. The Guidance Doctor, an Uplift employee, provides free consultations for HMF members, two hours per week at each of the 15 branches of APVS and PSW. The doctor gives preventive care advice, performs check-ups, writes prescriptions, gives referrals, and, at the time of the research, had started to provide a limited range of free medicines.

On average, the Guidance Doctor ranked in the middle of all the HMF services, however, perceptions of the value of the doctor varied widely across FGD groups. Those who perceived value in the Guidance Doctor did so because of the ability to get free checkups, to get referrals (as described above), and to save money. Members who lived at a distance from their branch office perceived this service to have less value, as it was too far from their homes to access affordably. A number of HMF groups had not heard of this service, perhaps because it was introduced more recently than other services.

Health talks

Health talks are provided to HMF members to raise their awareness of diseases and of preventive healthcare practices so that members seek care earlier and keep medical costs down. The topics of the talks vary widely but emphasize priority medical problems in the members' communities such as typhoid, appendicitis, anemia, seasonal diseases impacting the community, and general hygiene and nutritional issues. Talks are tailored to the season in which they are given. For example, malaria talks will be given during the rainy season when the disease is prevalent. The content of the talks is determined by Uplift staff. For example, if the Uplift doctors see many claims for the same medical event, they may suggest a health talk on this topic. The talks take place in the community or at group loan meetings, making them easily accessible to HMF policyholders. At APVS, all members are exposed to the health talks, as they are presented at the monthly group loan meetings. At PSW, the health talks are attended on a voluntary basis.

The research found that the health talks were ranked highly but by only a few of the FGDs resulting in a low overall score. One group rated health talks very highly, remarking that access to information was very important and in fact more important than referrals to hospitals. Some of the FGD participants recognized that the purpose of the talks was to promote disease prevention. One participant reported that:

> *"Health talk was very useful for us – they told us about swine flu and how to take care of ourselves." (Female, APVS, Non-Claimant)*

There were groups that perceived the health talks to have relatively less value because they duplicate services available elsewhere, although respondents did not elaborate on where else these were available. For example:

> *"Health camps and health talks are available anywhere [i.e. from other sources than Uplift] so they are not that important." (Male, PSW, HMF Claimant)*

The whole is greater than the sum of the parts

After ranking all the HMF services, FGD participants were asked: Suppose that Uplift had to eliminate one service, which one should it be? The purpose was to force a discussion of HMF features that members perceived to have less value.

During this discussion aspects of *expected value* were mentioned. Members perceive a benefit from the HMF program even if they do not use it at all, as they see others using services and know that they are available. Participants reported that:

> *"Nothing should be removed because everything is important. Even if we are not using any one of the services, others might use it." (Female PSW, HMF Claimant)*

> *"Even if a single person from our centre benefits from it, we will say that every one of us has benefitted." (Male APVS, HMF Non-Claimant)*

A minority of respondents were willing to trade off lower value services (e.g. discounts on drugs and OPD consultations and health camps) for increases in hospital cost discounts. In general, Ex-HMF members were more likely than current members to concede that a service could be eliminated.

Some members feel that less utilized services could be stopped. Only about 7% of the HMF members use any of the non-insurance features of the Uplift program in a given year, evidence that only a small number are benefitting from these services. This compares to an average of 2% of members who submit an insurance claim in any given year. What is surprising is that so many members did not want any service eliminated even if they did not make use of them, suggesting that the majority of current HMF members perceive value in all aspects of the HMF program. In fact some participants felt that all of the HMF services are interconnected. As one participant put it:

> *"It [the HMF] is like a staircase, you cannot remove any one (stair) of it; otherwise other services will be affected." (Male PSW HMF Claimant)*

The HMF program has been designed to potentially deliver tangible value to all members, not just those who submit claims for hospital costs. The majority of respondents appear to be happy just knowing that they have access to the non-insurance services even if they don't use them. A smaller share of respondents noted that all the services work together to protect members financially and health-wise.

At the same time, HMF members are not aware of the individual cost of each of the HMF components. If the question had been posed in a way so that clients understood the cost of each service, the answers may well have been different. That said, premiums per member are quite low, and any savings to the policyholders from ending one of the services likely would be minimal. The question of the client value of the non-insurance components is more significant from Uplift's perspective because the HMF program is not yet sustainable, and these programs accounted for at least 14% of expenditures in 2010 (McGuinness, 2011). Our findings suggest that even though utilization of these services is quite low, Uplift could not easily eliminate any of the non-insurance services in order to boost the financial viability without substantial negative impacts on customer satisfaction.

Gains in efficiency if not use of services

Many of the program's services mentioned above play a role in improving access to care by offering timely information as well as by making the cost of care at private providers more affordable. Non-HMF participants reported different and potentially less effective sources of information, yet they did not report skipping care as a result of poor or insufficient information. When they need medical attention they go to their local doctor who advises them which hospital to go to. These Non-HMF participants were not very likely to ask others for advice:

> *"There is no point in asking anyone. It's better we go directly to the hospitals." (Female Non-HMF participant)*

In comparison, the majority of HMF Claimant participants reported that they obtained guidance from the HMF program about where to go for healthcare. Some mentioned that the HMF program required members to consult with staff before accessing care. For some, access to information appears to be more important in situations such as emergencies.

Given that Uplift referrals steer policyholders to low-cost healthcare providers, Uplift's information-based services also lower financial barriers for the members who use some type of referral.

> *"I had a heart attack. I called the SE, they asked me to get admitted at S. Hospital (a network hospital). Normally they do not admit the patient without admission charges. But (the SE) called them and asked them to admit me. I was directly admitted to the ICU. This is a great help during emergencies." (Male PSW HMF-Claimant)*

Information about where to go for care is more highly valued by HMF members than non-members, again suggesting a market segmented in ways that are not easily observable.

Perceptions of service quality influence perceived value

The perceived quality of service may play a large role in explaining why respondents placed such high value on a product that few of them had experienced in full by using most or all of its components.

When asked to name the types of providers participants went to for medical care in case of serious illness or accidents, participants in slightly more than half the FGDs preferred to go to private hospitals. Uninsured participants were more likely to report that they preferred or went to government hospitals (3 of 4 FGDs). The HMF members appeared to have a more negative view of government hospitals and a stronger preference for private hospitals.

Three factors seem to drive participants' perceptions of hospitals: cost, proximity and service quality. All participants agreed that private hospitals are more expensive and that treatment at government hospitals can be significantly less costly. Deliveries were singled out as being much cheaper and hence government hospitals are often used for giving birth.

However, most participants were also concerned about the proximity of the hospital that they used partly due to the time and cost of getting there, particularly for family caregivers (see McGuinness 2011).

> *"…since government hospitals are far away they do not go there even if it is cheaper. They will have to spend on commuting." (Female PSW HMF member)*

In cases of severe illness requiring specialists, participants recognize that they need to travel to larger hospitals including government hospitals. The FGDs were held in different locations within Pune city; as a result, the perceptions of focus group participants on proximity of some of the larger hospitals, both public and private, varied.

The final factor in perception of hospitals is the service quality. This has been defined by Michielsen as comprised of two parts: "technical quality," which refers to proper diagnosis and treatment, continuum of care, and no overprescription or unnecessary treatment, and "interpersonal quality," which includes the respect and attention given by staff to the patients (Michielsen, 2010). Focus group participants had little to say about the technical quality of the private hospitals that they attend but rather focused on interpersonal quality or customer service. Discussions of quality in general were driven by what people don't like. Public hospitals, and in particular a specific large state-owned hospital in Pune, came under criticism for long wait times and a lack of attention.

> *"In cases of emergency we cannot keep waiting in the government hospitals." (Female, APVS HMF Claimant)*

> *"If there is somebody you know there [in the hospital], then things move faster; otherwise it is a very slow process. Nobody pays attention to you. People keep on moving here and there." (Male, Non-HMF)*

Key informants report that the public hospitals are overwhelmed with far more patients than their capacity. Getting staff attention just to find out where to go often requires a bribe. It can take hours to get admitted. Uplift staff report that they assist members in getting admitted to public hospitals, but no one in the FGDs reported receiving this assistance. Overall, FGD participants considered the interpersonal quality of government hospitals to be very low.

In addition to poor customer care, some FGD participants are of the opinion that the technical quality of public hospitals is poor, in terms of the drugs and treatment provided:

> *"People fear about the fact that if the treatment is not good in the government hospitals, then the patient might die…" (Female APVS HMF member)*

Key informants at Uplift and at healthcare providers contend that the technical quality of care at government hospitals is good. One FGD participant expressed a more nuanced view of government hospitals:

> *"S. Hospital is for the poor people. People generally go there at the last stage [of their illness] and after they have been rejected by other hospitals. And when they die, the hospital gets a bad name. It is a very good hospital…" (Female, Non-HMF)*

Participants tended to be more concerned with interpersonal quality (i.e. customer care) than with technical quality, likely because they lack the information to make judgments about the relative technical quality of healthcare providers.

A majority of focus groups expressed a preference for private hospitals, based on proximity and better interpersonal care, despite their higher cost. At the same time, some participants acknowledged that they or their neighbors use government hospitals because they are more affordable. Nevertheless, Uplift appears to have increased access to the private hospitals that HMF members prefer by lowering financial barriers to these healthcare providers. Similarly, MILK's Client Math study of Grameen Koota's hospitalization microinsurance in Karnataka, India, found that the insurance seemed to have increased access to private facilities among a group that would be unlikely to use such facilities without insurance (MILK Brief #12). At the same time, to the extent that HMF members follow referrals from Uplift, they will be accessing care that meets Uplift's quality standards, which may provide some assurance of quality even for those who are not using their preferred provider.

Analysis

The findings suggest that the perceived client value of the health microinsurance product depends on in large part on their perception of its ability to overcome various barriers to accessing effective healthcare. The study found that members face barriers to access and use of medical care related to affordability, bargaining power, and insufficient information about the healthcare options available to them.

The financial value of the HMF product is the top priority for policyholders. Not only is the direct cost of treatment and particularly hospital care of concern to HMF members, but indirect costs of time and transport to get to and from the hospital. The financial value provided by the HMF through claims reimbursement is the most highly valued feature of the program, for claimants and non-claimants alike.

Our prior study suggested that insured claimants with malaria benefitted financially from several aspects of the insurance: discounts at in-network hospitals, claims reimbursements, and discounts at family doctors, at drug stores and at diagnostic labs (McGuinness, 2011). However, this study reveals that not all HMF features that provide financial value were appreciated. This is evidenced by the fact members did not place much value on discounts for outpatient care or prescription drugs while they placed a high value on the referral features which help them save money through lower searching costs and more efficient service when they are guided to the appropriate hospital.

The financial value provided by the HMF features is important, yet ***affordability is not the only concern for members. Barriers to accessing effective medical care due to insufficient information about the healthcare landscape are also a concern.*** This was demonstrated by the high ranking of the referral features of the HMF, of which the 24/7 Helpline is by far the most popular and highly regarded.

> *"People really value the referral system. If members do not get a claim, if they don't go to the health camps or health talks, at least they can talk to the doctor and get help." (Uplift Manager)*

The referral system provides answers to the questions: *Who is the right doctor? What is the right treatment? And what is the right cost?* Members perceive great value in the referrals because they provide assurance that they will get the proper treatment and not be overcharged, confirming Uplift's early finding that information is one of the services most in demand by the members.

In combination with the provider network established by Uplift, the referral features ensure that members can identify and obtain appropriate medical care. Obtaining access to private hospitals in the network through the insurance does not simply address the affordability barriers that households face, although Uplift has shown itself to be particularly effective at negotiating bulk price discounts for members. It is also a matter of quality of care and members' perceptions of the effectiveness of care. Upon closer scrutiny,

the discussions around using private hospitals were also about access to dignified healthcare through better bargaining power.

With Uplift on their side, members receive more courteous, respectful and timelier attention at the hospital. Not only is the customer care at private hospitals generally better than at government hospitals, members feel that they receive better personal treatment because the providers know that Uplift is looking out for their welfare. ***The research suggests that Uplift plays an important role as a champion for the medical rights of its members.*** Members feel emotionally supported by the fact that they can receive healthcare guidance from the 24/7 Helpline or have Uplift advocate on their behalf at hospitals.

Members perceived less value in the HMF activities that address barriers to adopting better personal health behaviors such as health talks that provide preventive healthcare information or health camps that provide information on members' health status. This may be because the benefits of these services are less immediate: if the benefits of preventive and outpatient services lead to improvements in health over time, they may be better recognized by members.

Finally, the research showed that ***HMF members derive significant expected value from the program, through the peace of mind it brings***. Members expressed value from knowing that others in their community are benefitting from the HMF program. Members perceived a benefit from just knowing that they could participate in some HMF activities, even if they did not actually participate. Although intangible, the peace of mind from knowing that they have access to services (both the insurance and the additional services) appears to provide great value to members.

Conclusion

This study explored whether and how the Uplift members perceive client value in the HMF program. The study found that members perceive financial, expected, and service value in the HMF program, whether they have made claims or not. The financial value of the program was the most important aspect for members. The service value of HMF arises from several features, including those which address members' lack of empowerment, lack of knowledge of the healthcare landscape, lack of access to effective healthcare and lack of information about preventative healthcare. Of these, members prioritized assistance in navigating the healthcare landscape and access to effective care, particularly in terms of quality of care. The expected value generated by the HMF program includes improved peace of mind.

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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. Contact Michael J. McCord (mjmccord@microinsurancecentre.org), who directs the project, for more information.

Appendix 1: Implementing partners

The Uplift implementing partners are responsible for promoting the health microinsurance program, enrolling members, collecting premiums, collecting and performing an initial review of claims documents, and disbursing claims payments. They are also responsible for implementing the health management activities, such as health talks and health camps, and for supporting the Guidance Center by providing space. A dedicated Service Executive (SE) works at each NGO branch office to manage the HMF program in that area. The SE is the front-line staff person working at the branch level of the implementing partners and is the person responsible for providing these services to the insured members.

Parvati Swayamrajgar (PSW)

Parvati Swayamrajgar offers microcredit, health microinsurance and business development services in order to improve the living standards of slum residents in Pune. PSW currently has about 4,800 microcredit clients, over 5,000 HMF policyholders and nearly 18,000 HMF members. The health insurance is compulsory for all PSW borrowers who do not have existing health insurance. PSW lends to women and men, with the vast majority of borrowers being women.

Annapurna Parivar Vikas Samvardhan (APVS)

Annapurna Parivar Vikas Samvardhan (APVS) reported 14,668 policyholders and 54,461 HMF members at the end of 2010. APVS is one of a family of programs offered under the Annapurna umbrella. The Uplift health microinsurance is compulsory for all microcredit borrowers at APVS. Customers are not allowed to purchase the health insurance only, but instead purchase HMF coverage as they receive their loan disbursements. The Annapurna microcredit program lends to married women between the ages of 18 and 60.

PSW has seven branch offices and APVS has eight within the confines of the city of Pune (i.e. Pune Municipal Corporation).

Appendix 2: Methodology

This research was carried out using qualitative methods, including focus group discussions (FGDs) with current, former and non-members of the Uplift program and in-depth individual interviews (IDIs) with key informants. A short questionnaire was used to collect socio-economic data from focus group discussion participants. FGDs were held in the community, while IDIs were usually conducted at the office or place of business of the key informant.

Research participants were organized into focus groups according to their level of use of the HMF program and included:

- Current HMF members who had submitted a claim within the past two years (HMF Claimants)
- Current HMF members who have not submitted a claim (HMF non-Claimants)
- Former HMF members (Ex-HMF) who were members of HMF in the past but no longer participate
- Non-policyholders (Non-HMF), or individuals who live in the same neighborhood as policyholders, have never joined the HMF program, and had someone in their household who had been hospitalized in the past few years

Focus groups were segregated by gender to ensure that women's voices would be heard and their concerns taken into consideration. The first three sample groups were selected from the client databases of four branches, two at each of the partner MFIs. The Non-HMF members were selected by an MFO consultant with the help of HMF staff who worked in the communities. While the original study design intended to achieve equal numbers of groups for men and women, the researchers were unable to find enough male Ex-HMF members who were willing to attend an FGD, substituting a women's FGD instead.

Focus group discussions were held in the community, often within the branch offices of the respective microfinance partner. Informed consent was obtained verbally from all participants in the focus group discussions.

In-depth individual interviews were held with staff at Uplift and the partner MFIs as well as with health care providers at hospitals and out-patient clinics. HMF policyholders who serve as claims committee representatives were also interviewed individually. The purpose of these interviews was to investigate the perspectives and perceptions of these stakeholders with respect to the key research questions. The claims committee representatives, also HMF policyholders, were interviewed at the branch office of their MFI or at their home. Informed consent was obtained in writing from all key informants.

Appendix 3: Respondent samples

Table A1: Sample Frame of Focus Group Discussions

Sample Groups	Men		Women		Total
	APVS	PSW	APVS	PSW	
HMF Claimants	2	2	2	2	8
HMF Non-claimants	1	1	2	1	5
Ex-HMF		1	2	1	4
Non-HMF	1	1	1	1	4
Total	***4***	***5***	***7***	***5***	***21***

Table A2: In-depth Individual Interviews with Key Informants

Stakeholder Institution	Number of Interviews
Uplift Staff	6
APVS Staff	8
PSW Staff	9
Out-patient doctors	2
Hospital doctors or administrators	6
Claims Committee Representatives	4
Total	***35***

Appendix 4: FGD sample profile

The focus group discussion (FGD) participants came from established slum communities within Pune city where Uplift's NGO partners are active. Generally, the participants live in difficult economic conditions and have low levels of education and awareness of health issues. All FGD participants were asked to provide basic socio-economic data at the time of the interviews.

The FGD participants were mostly women (76%) due to the unavailability of many men during work hours. The average age of participants was 38, with that of Non-HMF group being slightly higher than average. Most men in the FGDs were literate while about 75% of female participants were literate. The Non-HMF women were more likely to be literate than the HMF-Claimant women. Male participants were more educated than females, with 47% of men having completed secondary school as compared to 24% of women. The HMF members were on average more educated than the Non-HMF participants.

About two-thirds to 75% of the participants had worked in the past year, either as wage employees or as self-employed workers. This implies that about 25% to 30% of the sample was unemployed in the previous year. Many of the women participants work as housemaids while men work in construction or as casual laborers. Self-employed participants typically managed small businesses, such a vegetable or food vending, home tailoring, and auto-rickshaw operations. Better paid, permanent jobs were rare among the participants.

Even though the FGD respondents and their communities are considered poor in absolute terms, a range of socio-economic segments within the research communities were identified and described during the discussions. The sample communities are perceived to include poor, medium (or middle) income and rich households. Poor households were characterized as headed by a single woman, typically either a widow or a woman whose husband was alcoholic. Poor people are employed in casual labor and seasonal and domestic work, earning an average monthly income of INR 1,000 to 2,000. Their children do not attend school. Medium income people work in small trade activities, usually have more than one source of income, and send their children to school. Monthly, these households will make about INR 4,000 to 5,000. Rich households have permanent jobs or manage larger businesses and more than one source of income, earning on average more than INR 7,000 per month. The populations of the communities in which the FGDs took place varied, but it was reported that between 10 to 30% of the population fell in to the poor category, 50 to 60% into the medium income category, and 10 to 40% into the rich one. Participants reported that only the poor and middle income groups join APVS and PSW, and thus benefit from the HMF program. These descriptions align with Uplift program data, which show that in a socio-economic sense, HMF members straddle the poverty line. See Appendix 5 for tables of participant socio-economic data.

Appendix 5: Summary statistics on FGD sample

Table A5.1 Socio-Demographic Statistics of FGD Participants by Sample Category

Indicators	Sample Category				Total All Groups
	HMF Claimant	HMF Non-Claimant	Ex- HMF	Non-Insured	
Number of Groups	8	5	4	4	21
Men's Groups	*4*	*2*	*1*	*2*	*9*
Women's Groups	*4*	*3*	*3*	*2*	*12*
Number Of Respondents	63	32	24	29	148
Men	*22%*	*22%*	*25%*	*31%*	*24%*
Women	*78%*	*78%*	*75%*	*69%*	*76%*
Average Age Of Respondents	37.1	38.1	38.2	40.4	38.2
Percent Of Respondents Who Are Literate	75%	84%	83%	83%	80%
Men	*100%*	*100%*	*100%*	*78%*	*94%*
Women	*67%*	*74%*	*78%*	*85%*	*75%*
Marital Status					
Married	89%	100%	96%	97%	94%
Single	5%	0%			2%
Widowed	5%		4%	3%	3%
Divorced/Separated	2%				1%
Ration Card					
Above Poverty Line	13%	22%	4%	10%	13%
Just Above Poverty Line	70%	53%	67%	69%	66%
Below Poverty Line	14%	22%	29%	21%	20%
Number Of Years In NGO	5.6	3.4	3.2	n/a	4.5
Number Of People In Household	4.6	4.8	4.6	5.1	4.7
Number Of Economically Active Persons In Household	2.0	2.3	1.8	1.8	1.84
Percent Of Respondents Who Engaged In Wage Employment In Last Year	44%	22%	25%	31%	34%
Percent Of Respondents Who Engaged In Self-Employment In Last Year	40%	56%	46%	34%	43%

Table A5.2 Educational status of FGD participants by sample category

Sample category	Gender	N =	No schooling or never completed primary school	Primary school completed	Middle School Completed	Secondary School Completed	Completed High Secondary	More than Secondary School
HMF Claimants	Female	49	33%	12%	35%	16%	4%	0%
	Male	14	0%	21%	29%	21%	14%	14%
HMF Non-Claimants	Female	25	20%	12%	32%	32%	4%	0%
	Male	7	0%	14%	29%	14%	29%	14%
Ex-HMF	Female	18	28%	11%	33%	17%	6%	6%
	Male	6	0%	0%	33%	33%	17%	17%
Non-HMF	Female	20	15%	30%	40%	10%	5%	0%
	Male	9	33%	22%	22%	11%	11%	0%
Subtotal	***Female***	***112***	***26%***	***15%***	***35%***	***19%***	***4%***	***1%***
Subtotal	***Male***	***36***	***8%***	***17%***	***28%***	***19%***	***17%***	***11%***
Total	**All**	**148**	**22%**	**16%**	**33%**	**19%**	**7%**	**3%**

Table A5.3 Asset Ownership of FGD Participants by Sample Category

Indicator (household assets)	HMF Claimant	HMF Non-Claimant	Ex- HMF	Non-Insured	Total
Owns a phone	59%	44%	29%	62%	**51%**
No access to a mobile phone in HH	4%	22%	29%	18%	**8%**
HH owns a working TV	90%	97%	83%	90%	**91%**

Table A5.4 FGD Participants' Membership in HMF Program by Sample Category

Indicator	HMF Claimant	HMF Non-Claimant	Ex- HMF	Non-Insured	Total
Average number of years borrowing from APVS/PSW	5.3	3.3	3.2	n/a	4.4
Currently has a loan	97%	88%	38%	n/a	66%
Average Loan Amount (USD)	347	240	168	n/a	n/a
Savings at APVS or PSW (USD)	83	46	n/a	n/a	n/a
Years participating in HMF	5.30	3.39	2.38	n/a	4.53