MILK Brief #12: "Doing the Math" in Karnataka, India[1]

Studying Grameen Koota's health insurance in India

Health financing is an enormous challenge among low-income populations; low- and middle-income countries bear 93% of the world's disease burden but account for only 11% of health spending (WHO, 2000). Low-income people piece together a variety of strategies to cope with health shocks: they forego care or use less expensive providers, draw down savings, sell productive assets, borrow, and reach out to family and friends. Health insurance has great *potential* to fill the remaining gaps in ability to cope with health risks (see box), and may in some cases be preferable to alternatives in terms of financial and health consequences. Nonetheless, we know relatively little about how it functions in the economy of low-income clients.

Potential value of health microinsurance

- health & service value
  - Increase utilization of healthcare services
  - Improve access to quality healthcare services
  - Improve health outcomes
- financial value
  - Decrease out-of-pocket spending
  - Reduce reliance on burdensome financing strategies
  - Smooth consumption

Against this backdrop, the MILK project collaborated with Grameen Koota, a microfinance institution based in the State of Karnataka, India, to study its voluntary health insurance program. Clients receive low-cost inpatient coverage coupled with access to a broad range of discounted outpatient services. We explored some open questions about the value of health microinsurance by assessing how clients coped with a relatively common but serious health shock: high fevers that required inpatient care. While the study focuses on understanding the financial value of the product, it also reveals insights into the product's service quality and into clients' perceptions of the product and demand. We find that the insurance alleviated pressures on direct hospitalization costs, but indirect costs were still high, especially opportunity costs for women clients of Grameen Koota who did not own their land but worked as laborers or in trade.

Focus group discussion with insured clients of Grameen Koota

Grameen Koota's Health Care Program

Working closely with Grameen Koota, a microfinance institution based in Bangalore, India, and its insurance partner, SAS Poorna Arogya Healthcare (SAS), the MILK team conducted a Client Math study to explore the financial value[2] that clients obtain from enrolling in Grameen Koota's health care program.[3] The health insurance product is voluntary and only offered to Grameen Koota borrowers. It includes coverage for inpatient admissions for a wide range of basic and specialist care, including fevers, pneumonia, general surgeries, gynecological complications, urology and orthopedic surgeries. The services are provided on a cashless basis (rather than requiring clients to pay out of pocket and seek reimbursement) at any networked hospital; there are currently over 60 private hospitals in SAS's network that are located in districts where Grameen

[1] This MILK Brief was prepared by Barbara Magnoni, Emily Zimmerman and Taara Chandani. (July 2012)

[2] MILK defines "financial value" as the value of microinsurance, when claims are made, in comparison to alternatives, including effects such as reduction of out-of-pocket expenditures, protection of assets, reduction in borrowing, and cash flow smoothing (Magnoni & Zimmerman, 2011).

[3] Sigma Research, a private research consultancy based in India, managed the field work and data entry.

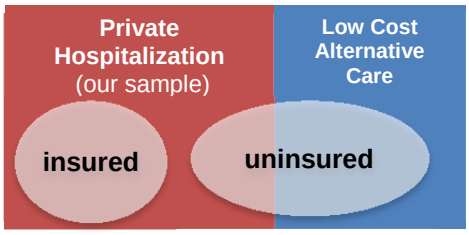
Koota clients reside.[4] As of January 2012, 106,500 clients had enrolled in the program. These represent nearly a third of Grameen Koota's 350,000 borrowers. Clients pay annual premiums ranging from USD3.20 for an individual to USD32 for a family of ten. Clients and covered family members can access coverage up to a single overall limit; this ranges from USD102 to USD1,015 depending on the number of lives enrolled. One of the key features of the scheme is a 20 percent discount on outpatient consultations from networked hospitals. SAS maintains an inpatient claims ratio of 80 percent, which is strong compared to industry standards in India.

Methodology

This Client Math study aimed to understand how insured and uninsured people coped with a discrete, recent hospitalization event and the financing methods they employed in doing so. We also asked whether the insurance helped smooth household consumption when frequent outpatient care was utilized by clients. A second set of questions explored the service value and outpatient health seeking patterns of clients; specifically, we asked whether the insurance resulted in non-financial benefits such as improved quality of care or client awareness of reputable providers.

The study was launched in November 2011 in five districts of Karnataka.[5] We randomly selected and interviewed 27 insured people who had made claims and 28 uninsured respondents from common districts across the state.[6] An important characteristic of the sample was that all respondents were hospitalized within three months before the interview; this offered a discrete health shock to reflect on and promised a high recall of financial information.[7] We focused only on hospitalization resulting from **typhoid fever** and **gastroenteritis**, relatively low-cost hospitalization events that require only a few days of admission. We chose these illnesses because they result in similar hospital stays, treatment regimens, and expenses related to tests and medications. SAS's reimbursement for hospitalization is capped at USD40 for both of these fevers, compared with USD122 for appendicitis and USD200 for hysterectomies; the average length of stay ranges from 2-3 days for fevers to five days for surgeries. It is important to note that the USD40 cap is calculated based on a discounted list of services, while for uninsured patients, it is likely that the same services could cost well above USD40. Both fevers are common in poor households and an important driver of claims amongst the insured, representing 20 percent of SAS's annual claims. Because the fevers are largely preventable water-borne illnesses they present an important opportunity for health education and outreach; thus, there was mutual interest by all partners to focus our study on these.

The insured and the uninsured: Who were they?



They seek care differently. We interviewed both insured and uninsured patients and their relatives who received treatment for these diseases at several network hospitals, but not those who skipped care altogether, used public services, traditional medicine or other cheaper, private alternatives. The uninsured respondents' ability to pay for services at these hospitals likely differentiates them from another potential group of uninsured respondents: those of the same community who suffered similar illnesses but did not seek medical attention or sought cheaper sources of treatment. As a result, *our comparison likely overestimates the ability of all uninsured members of the community to pay for health services*. Indeed, the existence of this third group is implied by the fact, discussed below, that the uninsured had greater financing capacity than the insured.

[4] The SAS network includes 108 hospitals across the state, which are also available to clients should they travel outside their districts.

[5] These were Bhadravathi, Chamarajanagar, Hassan, Mandya and Mysore Districts.

[6] The uninsured clients were randomly screened and contacted by three hospitals in the network, the same institutions at which many of the insured were also admitted.

[7] Recall for this time period was tested prior to implementing the study through focus groups with clients of the program.

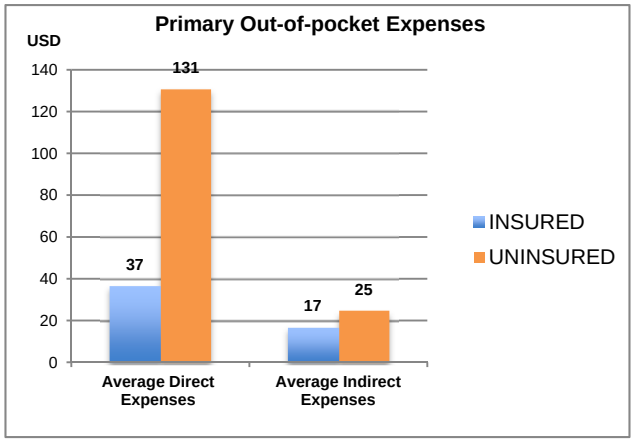
The insured and uninsured differed in their gender composition and financing capacity, but were alike in most other dimensions. While the insured and uninsured that we interviewed were similar in most respects (see table),[8] there are notable differences in respondents' gender and capacity to finance the illness. The largest source of employment for both groups was in agriculture (30% of insured and 36% of uninsured), though the uninsured were nearly twice as likely to own and work on their own land rather than someone else's. Trade and service businesses, such as running a provision store or tea stall, collectively comprised the second most prominent occupation amongst both groups. The insured and uninsured also had similar rates of home ownership (over 75 percent) and similar average household sizes of between 5 and 6 members.

Sample	Insured (n=27)	Uninsured (n=28)
Women (%)	85%	18%
Average age	35	35
Own home (%)	85%	77%
Average years of education	6.4	8.8
Average HH size	5.6	5.3
Average HH income (per month)	USD170	USD208

One important difference between the two groups was in the gender of respondents; the majority of insured respondents were women (85%), compared to less than a fifth (18%) of the uninsured clients. The gender difference can be attributed to the fact that the uninsured, households who were contacted through SAS's network hospitals and not affiliated with Grameen Koota, were more likely to appoint a male spokesperson to discuss their household's health and financial information. Grameen Koota clients (who are all women) instead chose to participate in the interview themselves given their direct affiliation to the MFI and familiarity with financial transactions managed with the institution. This gender disparity in the sample influences some findings that are discussed in the brief. For instance, the **average income** for insured respondents was less than half that of the average uninsured respondent (USD56 and USD124, respectively), although the average **total household income** between groups was much closer (USD170 and USD208, respectively). These household economic dynamics may reflect different levels of control over household finances between our respondent groups.

Enduring the hospitalization – The type and magnitude of expenses

Respondents were asked to report on a specific hospitalization episode for a fever-related illness that they or a family member underwent up to three months prior to the interview. As the chart to the right shows, the uninsured out-of-pocket spending was over three times what the insured spent for "**direct" hospital expenditures** (USD131 compared to USD37).[9] These included administrative fees, bed charges, doctors' fees, food, nursing care, medicines, medical supplies and laboratory tests. The package is **cashless** (insured patients receive covered services at almost no up-front cost, rather than being required to incur the costs and then be reimbursed), but the insured still incurred some out-of-pocket expenses. All insured patients pay a nominal registration fee upon admission, which averages USD2. In the event that clients chose a private room they are required to pay out-of-pocket since the coverage only applies to general



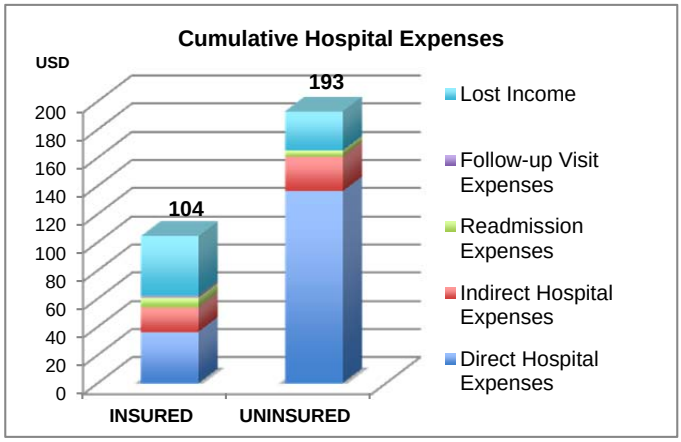
[8] Independent means tests indicated the differences between groups were statistically significant for the following variables: respondent income, gender and years of education; for other variables, the differences were random.

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

ward admission. Other out-of-pocket costs include specialized laboratory tests that are not conducted at the hospital or medications that are not included on the basic or generic list. The most significant direct expense that nearly 60 percent of insured patients incurred was for diagnostic tests, which averaged USD19 per hospitalization. It is important to note that all of the costs of inpatient care for the insured patients were negotiated between the insurer and health care providers and were offered on a discounted basis. This explains some of the difference between the USD37 paid by the insured and the USD131 paid by the uninsured, and it also helped maintain the premium for the product relatively low, averaging about USD1 per month per family.

On average, the uninsured also spent more on **indirect expenses** related to the hospitalization, though the difference between groups was substantially smaller. Indirect expenses are those incurred for transportation, managing a special diet, purchasing medications or conducting laboratory tests after discharge. The uninsured spent an average of USD25 for these expenses, compared to USD17 spent by the insured. Transportation and medicines accounted for the two largest sources of indirect expenditures for both groups.

A third set of costs that we tracked were **opportunity costs** - or lost household income - resulting from one or more household members missing work due to the hospitalization (including the sick person and/or those taking care of that person). It is important to think of these costs in terms of not requiring a specific cash outlay (no one was required to pay to miss work), but instead estimating the forgone income due to their absence. As such, these costs are most difficult to associate with the specific financing strategies discussed below. However, **these costs are large, in particular for the insured clients of Grameen Koota**. Interestingly, 63 percent of the insured missed work, compared with only 21 percent of the uninsured. A majority of the uninsured who reported *not* missing work were farmers with their own land, suggesting that they may not have experienced an actual loss from not working or that they did not view their time away as "days missed," particularly if another family member was able to fill in. For those who did miss work, the average loss in wages due to hospitalization was nearly the same between both groups: USD72 for the insured and USD70 for the uninsured. The average number of days missed was also similar, at 13 days for the insured and 12 for the uninsured. However, these averages can obscure the full picture; we analyze specific cases below to illustrate how the insurance worked for different types of respondents.



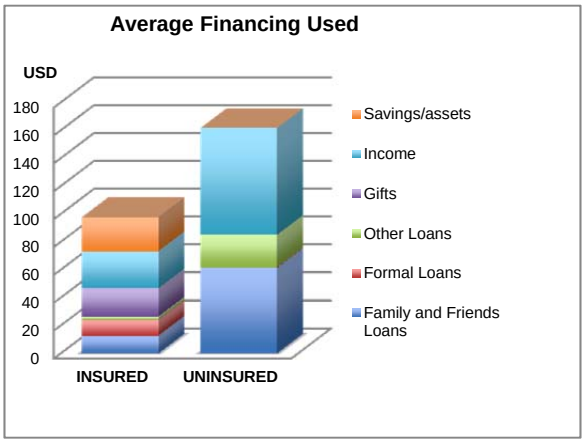
A final category of costs relate to **re-admission** and **follow-up visits**. Insured patients may in some cases spend more than the uninsured when insurance encourages new healthcare seeking behaviors, but does not cover the full cost of care, such as indirect expenses or follow-up care (Wagstaff & Lindelow, 2008). The average re-admission costs for the 3 people (11% of our sample) in each group who were readmitted were USD63 for the insured and USD37 for the uninsured. While re-admission was recommended for 30 percent of insured clients and 14 percent of the uninsured, very few actually followed up. The high costs associated with readmission, in particular for the insured group, were likely a disincentive to follow through on this second admission. When doctors recommended **follow-up visits**, which were included in the insurance coverage, insured patients were somewhat more likely to follow through (33 percent) compared to 14 percent of uninsured. The total indirect costs of these visits were low in comparison to re-admission, averaging USD5 for insured to USD2 for the uninsured, and were spent largely on transportation.

In summary, the **actual out-of-pocket expenditure**, without accounting for lost income, averaged USD62 for insured, compared to USD165 spent by the uninsured, the difference reflecting the coverage benefits as well as discounts negotiated with hospitals. Some of the difference is eroded when indirect and

opportunity costs are included, which lead to a **total average cost** of hospitalization of USD104 for the insured (61 percent of monthly household income) compared USD193 for the uninsured (93 percent of monthly household income). The next section discusses how both groups financed this expenditure.

Piecing together the financing

The burden of the costs was greater for the uninsured. To cover the cost of the illness, the insured reported using financing strategies that added up to an average of USD98, and the uninsured financed nearly two-thirds more at USD162. These reported financing sources represent 58 and 78 percent of gross household income for the insured and uninsured, respectively.



Both groups relied on loans as their dominant mode of financing, followed by income. The most prevalent source of financing for both groups was **loans**. On average, the insured borrowed much less (USD26) than the uninsured (USD85), representing 15% compared to 41% of their monthly household income respectively. Family and friends are often a quick and reliable source of support for low-income people in times of financial crises.[10] In the case of Grameen Koota clients, however, they played a relatively small role.[11] **The uninsured accessed most of their loans from friends and family** (interest free), and a nominal few reported using moneylenders and pawnshops. None of the uninsured approached a bank or MFI—even though many reported regularly banking at these institutions. They noted that family and friends were cheap sources of borrowing. The responses of the insured paint a different picture, however, suggesting that they may have been the more vulnerable group. The insured took out a nearly even share of loans from formal sources (Grameen Koota or cooperative societies) and from friends and family. The average amount borrowed, USD26, represented 15 percent of their monthly household income. Only one respondent approached a moneylender, a source that is considered by many Grameen Koota clients to be too costly. While this group felt that approaching friends and family was not a "bother," they seemed much less likely to have access to borrowing these sums of cash from their networks, and thus more vulnerable to the financial burden of this health shock.

Using income was also a commonly reported response to financing the shock, with 79% of uninsured respondents reporting having used household income to cover part of the shock. Once again, the insured group seems to have been more vulnerable. To begin, insured respondents' income only comprised 33% of their overall household income, compared to 59% for the uninsured. Of the insured, 59% reported using household income to finance the shock, but only 44% used their *own* income, compared to 71% of the uninsured (the others relying on other household members' income). The difference between insured and uninsured may be a result of the insured group being comprised of women, who had less control over the use of household income than their male counterparts. These insured women, instead, needed to piece together their income, in addition to some others' household income (including minors in two cases) to cover the cost of inpatient care. The responses for both groups on how they pay for outpatient care echo this finding. Insured respondents are much less likely than uninsured to use their own income, complementing this with other household income, as well as more difficult mechanisms such as selling assets and drawing down on savings (see charts below). Despite the harder time insured respondents had coping with these shocks, **extreme strategies for coping,**

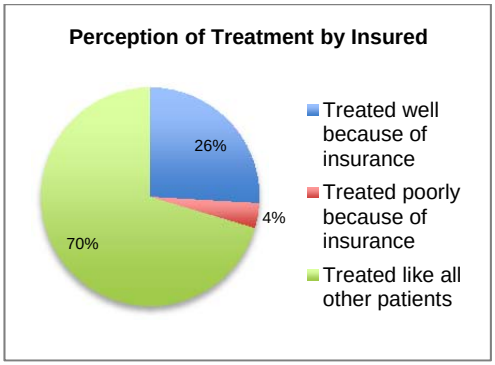
[10] Our Client Math studies of MAPFRE's Codensa funeral insurance product and MicroEnsure's Obra Pa property insurance product confirm this. See MILK Brief #8: "Doing the Math" - Cashless Funeral Microinsurance in Colombia and MILK Brief #10: "Doing the Math" with Property Insurance in Ghana

[11] We explore the role of family and friends in more detail in MILK Brief #5. While family and friends have traditionally played an important role in coping with shocks and continue to do so in many contexts, we identify some demographic trends that may point to a weakening of access to these tools for others.

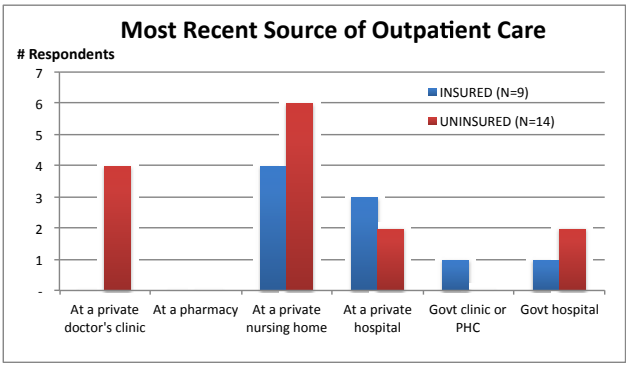
including reducing consumption on food, schooling or medicines were not reported by either group for inpatient or outpatient health care.

What Can We Say about Service Value and Outpatient Care?

Service value of insurance is important—not only in terms of care but also in the "status" it offers insured patients in interactions with providers. Respondents were asked about the customer care that they received at hospitals and whether they believed that having insurance influenced the quality of their treatment. Both groups were generally satisfied with the quality of services, reporting that medical staff was "attentive and courteous," but the uninsured were more likely to report a negative experience. Though a majority of the insured felt that insurance did not influence the quality of treatment and one person felt that it had a negative effect, a noteworthy 26 percent felt that having insurance **led to better care** (see right). The uninsured all felt that they were treated like other patients when asked this question. Positive sentiments about the quality of care were also expressed during focus group discussions, where the insured felt that the empanelled hospitals were of high quality and always ensured cashless treatment. For the poor, holding an insurance card that is honored at reputed private hospitals has great perceived value, especially when it promises cashless service. These sentiments may also have had an influence in encouraging insured patients to follow up and consult with their doctors after hospitalization, which, as noted above, the insured were more likely to do than the uninsured.



Awareness and use of the outpatient benefit was low, revealing an opportunity for client education to increase value. An important component of service quality is whether clients have access to the full range of **outpatient health care** that can complement less frequent but more serious hospitalization events. Grameen Koota offers partial outpatient coverage: clients receive a 20 percent discount for consultations at network hospitals. This coverage has potential to be an important feature to encourage use of preventive health care and early treatment from qualified doctors and to increase client satisfaction. Indeed, practitioner literature often suggests that clients are more likely to value a product with outpatient coverage, which, because it can be used more frequently, allows them to experience the insurance and builds trust by demonstrating that the product works and claims are paid as promised (e.g., McCord, 2007). However, results from our survey indicate that most clients (56%) are *not aware* of this benefit and many (30%) are *unsure* whether outpatient care is included. This low awareness represents a significant lost opportunity for both clients and the insurer. Out of nine clients who had used outpatient care in the past 3 months, only two went to a covered provider and received the discount. Insured clients were also more likely to use low cost or free government services than private providers (See chart above). **This suggests another flaw in the outpatient care: that its design may fall short of client needs.** Anecdotally, feedback from group discussions indicated that clients would rather go to a small (informal) provider who can provide a check-up and injection in one visit than pay a consultation fee – albeit at a discount – at a larger clinic only to then be referred to buy expensive prescriptions from a pharmacy. During these discussions, clients cited a desire for outpatient coverage but would rather not pay out-of-pocket to access it. This offers some insight into the research documented by practitioners that client demand for health microinsurance is often for outpatient coverage. While this may be the case, exactly which providers, type of services and financing mechanism are involved can affect the interest in and usage of outpatient care.



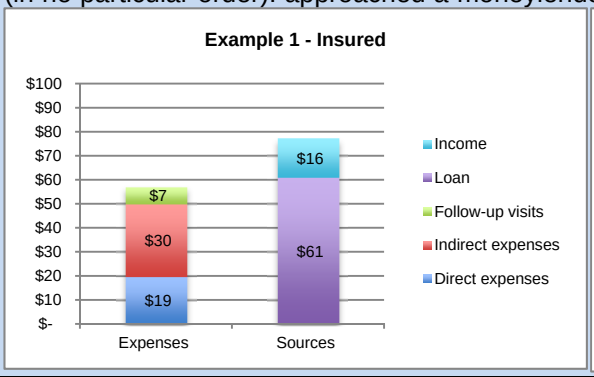
A Closer Look at Select Households

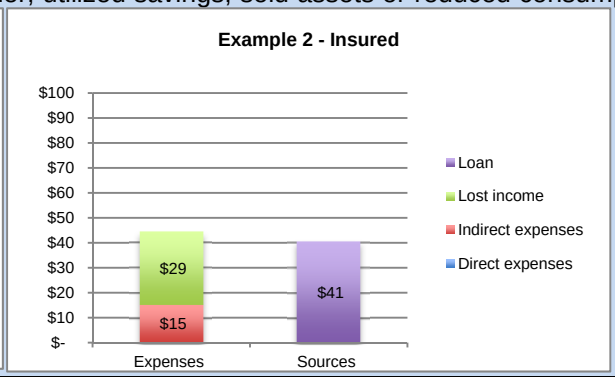
The overview above highlights broad trends that were observed in the study sample, but the average figures can obscure behaviors that unfolded within specific households. The following examples delve into four individual cases to shed light on their coping experiences and perceptions of service quality.

Insured households had substantially lower immediate or "direct" hospital expenses than the uninsured, and also tended to have relatively less earning power than the uninsured.

Example 1 illustrates the case of an ***insured*** married woman who lives in an extended family with eight people. She works on her family's land and did not report earning any independent income. Her household's monthly income is approximately USD81. She is one of the few respondents who is aware of and benefited from the product's outpatient benefit, recently receiving a 15 percent discount on a USD16 bill for a visit to an in-network doctor. In September 2011, she contracted gastroenteritis and was admitted to a nearby network hospital. She felt that she was treated with "sufficient" attention and courtesy, and did not perceive being treated any differently from those without insurance. She spent nearly USD20 on direct hospital costs, primarily laboratory tests and medicines (see Example 1 chart below). Her indirect costs were close to USD30, for transport, special food and her ongoing need for medicines and tests. The hospitalization was financed by a relatively large loan of USD61 from a moneylender and USD16 of household income (some of which was presumably used to partially repay the loan). The large discrepancy between total costs and total financing may reflect some overlapping of sources, as timing of the costs and availability of funds to pay them were unlikely to be perfectly aligned.[12] When asked how she would have financed the hospitalization without insurance, she responded that family or a moneylender were her top choices. While she regularly banks with MFIs, she believes they are unable to administer loans quickly enough to finance this type of shock.

In **Example 2**, we enter the home of an ***insured*** widow who heads a household of six people. She works as a farm laborer and earns USD40 per month, and her household's combined income is USD120. In addition to her loan from Grameen Koota she also borrows from a cooperative society and has a total outstanding loan balance of USD244. She was not aware of the outpatient coverage through Grameen Koota, though she remarked that fortunately nobody in her family has had to visit a doctor for a consultation in the last three months. However, her adult son fell sick with gastroenteritis and was hospitalized in September 2011. He was treated at a private hospital that she knew belonged to the network. She noted that the medical staff were "extremely attentive and courteous" and also felt that her son was treated well *because of the insurance*. The direct costs of the hospitalization included only a nominal registration fee of USD 0.20. The "indirect" costs of USD15 included transportation, special food, and medicine. Unsuprisingly, as laborers, the largest loss for the household was in missed wages. Her son missed ten days of work and she missed two days, for a cumulative opportunity cost of USD29. To bridge this income gap, she took a rather costly loan of USD41 from a friend, repayable in 6 months at a rate of 5 percent per month. Without insurance, she noted that she would have used all of the following strategies (in no particular order): approached a moneylender, utilized savings, sold assets or reduced consumption.



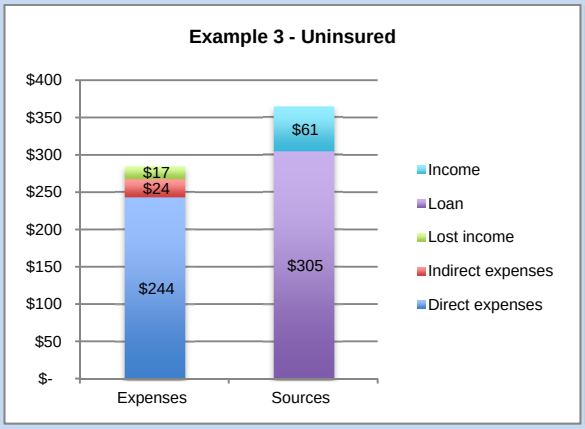


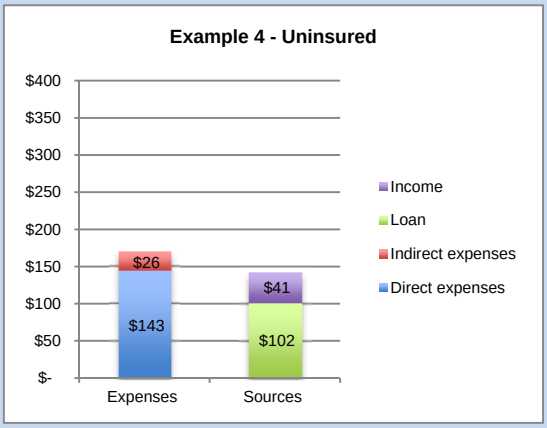
[12] It may be, for example, that when the loan was taken out, the full cost of the illness was still uncertain, or that some of the income that was diverted to pay for the hospitalization had not yet been earned.

The uninsured needed to make larger financial outlays, which required greater amounts of financing, though there was no reporting of "belt-tightening" or reduced consumption.

Example 3 represents a typical case of the ***uninsured***: a male respondent who heads a household of 8 people, with his own agricultural land serving as the household's main income source. He reported monthly income of USD168, which is supplemented with USD61 from others in the household. His typical sources of borrowing are commercial banks and friends and family, both of which he considers more "affordable" than other sources of financing. In October 2011, his wife was admitted to the hospital for a high fever; he chose a nearby private hospital because they had received quality services there in the past. They incurred relatively high direct costs at the hospital of over USD240 for tests, medicines, doctors and nursing fees, and presumably tied to the length of stay. Their indirect costs of USD24 were equal to the average expenditure made by the uninsured in our sample. The respondent himself missed three days of work caring for his wife, which he estimated cost him USD17. The household financed the total costs of USD283 by borrowing USD200 from family and USD100 from friends, both short term but interest-free loans. The respondent also used roughly USD60 of his own income to cover additional costs, suggesting some "churning" of mechanisms since the timing of the use of different mechanisms may not all have been immediate. When asked what he thinks about health insurance, the respondent remarked that he does not need it; the only type of insurance that he has heard about and would consider buying is life insurance. The fact that the family did not have to sell assets, reduce consumption or resort to borrowing from a moneylender suggests that the household did not perceive this to be a large overall burden, despite having to borrow to cover the cost. The benefit of insurance, which is relatively low cost, would have been positive even if the man had been paying into the program for 20 years (the annual premium is USD13 for a family of four), however, this benefit may not be large enough for the family to perceive a need since he managed to cope with the costs rather easily.

The final case, **Example 4**, also illustrates an ***uninsured***, male-headed household that derives its primary income from farming on its own land. The respondent, the husband, is the sole earner and reported monthly earnings of roughly USD170. As in Example 3, he has access to commercial banks, which he views as the most affordable formal financing source. His mother was recently hospitalized for gastroenteritis at a relatively large, well reputed private hospital. The family had to pay a total USD169 in expenditures, the bulk of which—USD143—was to cover direct hospital charges. The respondent's teenage son accompanied his grandmother to the hospital so the respondent did not have to miss work himself, and no opportunity costs were incurred. The family financed the expenditure by taking an interest-free loan of USD102 from a friend and diverting approximately USD41 of household income. When asked about his perception of insurance, the respondent noted that it is a valuable service but that it is only meant for the rich; still, he would consider buying health and life insurance for his family in the future.





Was it worth it?

The benefit of the insurance most affected the direct cost of hospitalization. Insured respondents had substantially lower direct hospital expenditures than uninsured patients, on average nearly *USD100* lower,[13] representing more than half of their monthly household income. Even **incurring one such hospitalization in 7.7 years would lead to a positive net benefit for the family, assuming their alternative would have been private care**. Higher-cost services such as appendicitis (USD122 coverage cap) and fractures (with a range of USD190-285 coverage caps), would make the product even more valuable when the less frequent event occurs. Grameen Koota's product combines coverage for a range of frequent and infrequent inpatient care, as well as outpatient discounts. This combination seems to help the "math" of the purchase decision lean in the favor of the client, as it becomes more likely that they will be able to use the product (as opposed to products that cover only infrequent, high cost hospitalizations). However, the relative benefit of the insurance is partially eroded when other associated costs are taken into account, including indirect expenses and in particular, opportunity costs. For example, lost wages were particularly high for the insured and potentially difficult to recover in the short term.

Our study offers suggestive evidence that Grameen Koota's health microinsurance may not have greatly reduced the financial burden of illness on insured households, but instead may have increased access to private health care services to a group that was otherwise unlikely to use these services, or that may have used them at a greater financial cost than the uninsured group we interviewed. The insured respondents' use of outpatient services suggests that this group was somewhat more constrained from using private health services in general. The insured were more likely than the uninsured to use public outpatient services, for example, and had a more difficult time covering their medical expenses with their own income, turning to other household income, savings, asset sales and other difficult mechanisms to cover these costs. This also suggests that some people who were uninsured but otherwise more similar to the Grameen Koota clients than to our uninsured sample were in the "missing" third group: those who fell ill but were unable to seek treatment, or turn to under-resourced public providers or poorer-quality private doctors for care instead.

Focus group discussion with clients of Grameen Koota who chose not to buy the insurance

While we saw only a few cases of extreme hardship as a result of the costs related to these hospitalizations, we found that the uninsured actually seemed to manage these costs with less strain than our insured respondents, despite having a larger bill to cover. They were able to avoid large opportunity costs by sending people to the hospital to accompany the patient who did not work or whose labor could be easily replaced. We also see some suggestion that gender may have contributed to the differences we see between the two groups' ability to cope. Though total household income was similar across groups, insured respondents were primarily women and uninsured respondents were primarily men, whose own income was higher and who presumably had more control over household financing decisions than the women in the insured group, including how much income to divert to the medical costs.[14]

Not surprisingly, the insured perceived value in the product, noting that their households benefited from the insurance ***financially***, that it offered them "***peace of mind***," and that it actually improved their ***health status***. Specifically, a majority felt that the insurance had an *improved effect* on their income (74% of

[13] This amount includes both the USD40 insurance coverage and provider discounts offered to covered services of those who are insured, and may also reflect some differences in the care-seeking behavior of the insured and uninsured.

[14] It is also possible that the uninsured men may have underestimated the full cost of the shock if they delegated the task of caring for the sick person to a female family member.

respondents) and reduced borrowing (78% of respondents). Over 95 percent of the insured felt that the insurance improved their actual health status – possibly resulting from a greater ability to "afford" a visit to a private doctor, access to preventive health information offered during Grameen Koota meetings, increased awareness about who qualified doctors are and greater confidence in approaching network doctors with an insurance card in hand. As the interviews revealed, many insured respondents also believed that the insurance led to improved treatment and quality of care at the hospital.

While the illnesses we studied appeared not to have been a large burden on the uninsured, the "math" suggests they too would have benefitted from insurance. Some respondents did show interest in becoming insured, but did not have access. A large number, however, were not knowledgeable about insurance. Of the uninsured, only 60 percent felt that they knew something about insurance, and 60 percent would consider buying health insurance in the future. Most who want to buy insurance believe that it will save them money, and most who would not consider buying it do not know anything about insurance (27%) or feel that they do not need it (7%). Grameen Koota's product offers respite, though not complete relief, from the high cost of illness, but its product is only accessible to its own clients and their families. Other products such as the government's subsidized RSBY insurance may be better at reaching a broader segment of the population. Over time, Grameen Koota's product may need to evolve to reflect growing access to universal coverage in India through RSBY. This will push Grameen Koota to identify the specific value the product offers and where it can differentiate itself or complement a subsidized inpatient product such as RSBY's. The high cost of indirect health expenses, particularly their opportunity costs, suggests that there is room to offer complementary coverage to relieve the burden of health expenses. For the time being, the current insurance product is offering some financial relief to Grameen Koota's clients. While this is not sufficient to alleviate the entire financial burden of their health crises, premiums are low enough to sustain a value proposition. More importantly, perhaps, there is some suggestive evidence that the product might be improving overall access to private care for these clients.

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