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REVIEW OF COMMUNITY/MUTUAL-BASED HEALTH INSURANCE SCHEMES AND THEIR ROLE IN STRENGTHENING THE FINANCIAL PROTECTION SYSTEM IN INDIA

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The Health Finance and Governance Project

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Photo: His clubfoot having been fixed by CURE Clubfoot India, Mohit runs and jumps in New Delhi, India.

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ACRONYMS

APVS	Annapurna Pariwar Vikas Samvardhan
CBHI	Community-based Health Insurance
CBO	Community-based Organization
CHNHBA	Calcutta Hospitals and Nursing Home Benefits Association
GHIS	Government Health Insurance Scheme
ICMIF	International Cooperative and Mutual Insurance Federation
IRDA	Insurance Regulatory and Development Authority
IT	Information Technology
KII	Key Informant Interview
KPI	Key Performance Indicators
MCCO	Mutuals, Cooperatives, and Community-based Organization
MFI	Micro-finance Institutions
MI	Micro-insurance
MSME	Micro, Small, and Medium Enterprise
NGO	Non-government Organization
OOP	Out-of-Pocket
RBI	Reserve Bank of India
RSBY	Rashtriya Swasthya Bima Yojna
SEWA	Self-Employed Women's Group
SHG	Self-Help Group
SKDRDP	Shri Kshethra Dharmasthala Rural Development Project

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EXECUTIVE SUMMARY

The Insurance Regulatory Development Authority of India recognized micro-insurance (MI) as a special category of insurance in 2005 to promote health insurance among the economically vulnerable sections of the population. The new rules for MI paved the way for larger participation of community-based health insurance schemes in the distribution of MI products. In 2015, the insurance regulator changed the rules and regulations of MI products. The new provisions brought clarity and formalized the role of community-based organizations (CBOs) such as cooperatives registered under Cooperative Societies Act, micro-finance institutions, and self-help groups to engage in MI.

The CBOs participate in MI using two different institutional approaches. The first approach is the partner-agent model. Commercial insurance companies develop the MI product and guide the process of determining prices and risk. The CBO is responsible for selling, distributing, and servicing these products as agents. Many community-based health insurance schemes adopted this partner-agent model of selling and distributing insurance products in India.

The second approach is the mutual model. In it, communities retain the risk, and they play a central role in designing, developing, pricing, distributing, and managing the health insurance program for the members of their communities. The mutual approach to health insurance has existed in India since before independence. Insurance legislation of 1938 explicitly defined mutual insurance organizations and later, the Insurance Regulatory Development Authority regulations of 2005 recognized mutual aid cooperatives as partners in the growth and development of the insurance sector, focusing in particular on vulnerable and economically weaker sections of society.

Some CBOs have chosen to operate according to the mutual approach, for the following reasons. The first is because premiums paid under the partner-agent model are higher for the same amount of coverage and are generally unaffordable to community members. The second is that the partner-agent model does not encourage (a) using a community-based approach to health seeking behavior, (b) integrating primary and promotive care approaches, and (c) building health awareness as an integral part of the scheme. Health mutuals are able to keep the premiums lower because they have an in-house claim management system with incentives to use low-cost facilities such as public and not-for-profit facilities. Initiatives by organizations such as the Development of Humane Action Foundation, Shri Kshethra Dharmasthala Rural Development Project, Annapurna Pariwar, and Uplift Mutuals suggest that the mutual approach has potential to meet health protection needs in India.

Currently, even with the advent of government health insurance schemes targeting the below-poverty segment of the population, about 58 percent of the Indian population remains without financial protection. Those left out include people just above the poverty line, members of credit societies, urban labor networks of migrants, and employees of informal, micro, small, and medium business clusters who do not meet the eligibility requirements of the government schemes. These groups have no access to programs that can protect them from financial risks. Mutual/community initiatives can play an important role in meeting their health protection needs. Over the years, initiatives by some organizations such as the aforementioned Annapurna Pariwar suggest that their membership has experienced a compound annual growth rate of 15 percent since 2011. The mutuals have developed community-tailored health insurance schemes, integrating them with the credit and other activities of the societies they belong to while focusing on primary health care needs. A key aspect of these programs is that product design is finalized through democratic processes.

The role of technology and experience gained over the years in claims and risk management play a critical role in the sustainability of these programs. Insights from field visits suggest that some of these programs have developed many innovative and supplementary approaches to mitigate risk. Examples of such initiatives include:

- Arranging discounts up to 10 to 30 percent for outpatient care
- Appointment of in-house medical officers who function as point of first contact
- Providing suggestions for pathways of care
- Helping communities understand health and financial risks through financial literacy programs

The governance structure of these institutions aims at creating social capital, which encourages trust and reciprocity among members. However, at times there are tensions in claim settlement. In such situations senior management engages in mediating in claim redressal and resolving the differences. Most community/mutual programs have a small membership base in a concentrated geographic area. Scaling up and expanding geographically may be considered an important strategy to diversify risk and ensure sustainability.

The report suggests focusing on following groups of organizations through which community/mutual-type insurance initiatives could scale up: (a) micro-finance institutions and self-help groups, (b) the more than 600,000 cooperatives in India, (c) micro-enterprise and small- and medium-size enterprise clusters, and (d) urban labor markets (such as auto driver unions) and migrant clusters in several cities in India. Seven cities have a population that is more than 40 percent migrant. These various groups have been identified for scale-up since they have a community focus and work at the grassroots level. Moreover, they are geographically widespread and reach the remotest parts of the country, enabling them to address the problem of access.

The report also observes that complete integration of primary health care into any mutual health program remains a challenge. There is a significant felt need to integrate primary care into mutual health insurance programs by finding ways to overcome the challenges, as improving access to primary care and providing financial protection to poor and marginal populations is increasingly viewed as an important strategy for improving health outcomes. The discussion suggests that this will require an in-depth understanding in areas such as (a) the nature and profile of outpatient care needs, (b) capturing data on outpatient service utilization, and (c) based on the data, developing an appropriate health insurance program and integrating it into the existing program.

The report further notes that the voluntary form of health insurance experiences much bigger market failure challenges. These interventions are known in theory and practice as having sustainability and scalability challenges. However, this does not mean such interventions are not useful. When leadership and management know the challenges, they can make a difference in mitigating many of the unintended consequences of this instrument.

1. BACKGROUND AND OBJECTIVES

The Insurance Regulatory and Development Authority (IRDA) of India recognized the concept of micro-insurance (MI) for the first time in 2005. Since then there have been many developments concerning the health insurance products offered by community-based organizations (CBOs) in India. The regulations of 2005 paved the way for the partner-agent model[1] of insurance, under which CBOs could participate as distribution agents to offer health insurance products to their communities. The alternative community/mutual approach to health insurance has existed in India since before independence. The insurance legislation of 1938 explicitly defined mutual insurance organizations. The 2005 regulations made reference to mutual aid cooperatives as partners in the growth and development of the insurance sector focused on vulnerable and economically weaker sections of society and bringing in the MI approach. More recent regulations of 2015, however, make reference only to cooperative societies as partners in the distribution of insurance products. The mutual model of insurance did not get adequate attention. In contrast to the partner-agent model, which commercial insurance companies promote and implement, communities take a leadership role in the mutual model. As these programs are primarily community driven, their mode of functioning is expected to provide sustainability to their initiatives.

Using case studies and a review of the literature, this report discusses the role and functioning of community/mutual-based health insurance in India and suggests how some of the innovative approaches adopted by these organizations to mitigate consequences of out-of-pocket (OOP) expenditures on health care can be further strengthened. This is of immense significance in light of the fact that India has one of the world's highest percentages of OOP spending on health, 67.1 percent of total health spending compared with the global average of 29 percent. Given that public spending on health, at 1.15 percent of gross domestic product, is one of the lowest in the world, the current level of OOP spending is likely to persist unless efforts are made to rein in CBOs and non-government organizations (NGOs).

The study recognizes that voluntary forms of health insurance experience market failure challenges. These interventions are known in theory and practice as having sustainability and scalability challenges. However, this does not mean such interventions are not useful. Many initiatives have been attempted at the community level in several countries over the years. When leadership and management know the challenges, they can make a difference in mitigating many of the unintended consequences of this instrument.

[1] In the partner-agent model, commercial insurance companies develop the MI product and underwrite the process of arriving at the price and risk while the CBO is responsible for selling, distributing, and servicing these products as agents. Under the mutual model, the risk is retained by communities. They play the central role in designing, developing, pricing, distributing, and managing the health insurance program developed for the members of their communities. Therefore, the mutual model is better suited to the needs of the community than is the partner-agent model.

2. METHODOLOGY

This report is the outcome of an extensive desk review, including a review of case studies of health mutuals and CBOs, and analysis of key informant interviews at one CBO.

The study team began by studying the constituents and characteristics of health mutuals, their history, and their evolution. A preliminary review revealed that there is no comprehensive list of health mutuals in India, so the team reviewed various sources and generated a list of health mutuals and CBOs. Because there is no standard definition of health mutual, especially in India, it was a challenge to categorize such organizations. That said, the pre-release draft of the landscape study by the International Cooperative and Mutual Insurance Federation (ICMIF) and Insurance Institute of India does mention about 15 health mutuals and cooperatives spread across 13 states. These mutuals and cooperatives provide insurance services to about one million people using either a risk-retention or risk-sharing model (III and ICMIF, 2016). An MI compendium published by the International Labor Organization and micro-finance state of practice reports published by different agencies constituted other sources of information about health mutual schemes in India (Fischer, 2006; Sa-Dhan, 2014a; Sa-Dhan, 2015). During data collection, the team observed that while several bottom-up health mutual schemes have started in India, very few have survived intact; some have chosen to cooperate with various social security schemes (Shailabh, 2016). The micro-finance state-of-the-practice report of 2014 lists 43 micro-finance institutions (MFIs) in India providing MI products to 15.83 million beneficiaries. Each of the organizations' websites was searched to find products that qualify as a health mutual. Eventually, a list of 21 MFIs (small and large) qualified as a health mutual. Eleven were identified as mutuals that fit the purpose of this study based on the criteria set for the review. The criteria were: (a) being in operation for at least five years, (b) having size and coverage of at least 15,000 members, (c) coving primary care and a package of other services, and (d) using technology to enable services. (See Annex A for the list of mutuals identified.)

2.1 Reviewing the Literature

For the literature review, the team searched several databases that included peer-reviewed and trade publications in English. The key databases were Academic Search Complete, Google Scholar, PubMed, Scopus, and Web of Knowledge. There were 1,527 search results using the following keywords: mutual health insurance, cooperatives, micro-health insurance, CBOs, ICMIF, India, South Asia, low- and middle-income countries, regulatory framework, and legislative framework. In advanced search options, we activated only academic journals and trade papers. An additional selected literature search improved understanding of the constituents and characteristics of health mutuals and cooperatives and their history and evolution. Based on this, we identified 154 papers. After applying advanced search options and removing duplicates, abstracts of 430 papers made the short list for review. We appraised the full text of 71 papers. Industry reports, conference papers, case studies, organizations' websites, and expert opinion were particularly helpful in writing this review and complementing information that was otherwise not available or could not be retrieved from the systematic search of databases.

The literature review helped in understanding various aspects of health mutual and MI schemes, ranging from their origin to their design, challenges, and insights into how these schemes have been used in different countries to improve the health status of their population. The scope and potential of CBOs/mutuals are discussed in Section 11. Some of the papers and other literature reviewed were not about health mutuals. Nonetheless, they contributed to understanding the different models that could help with health care service provision in a country as diverse as India.

2.2 Field Visits and Key Informant Interviews

After the literature review, we conducted a field visit to the Annapurna Pariwar office and also held several e-discussions with its staff. Annapurna Pariwar is a well-known organization that implements a mutual health program. (See Annex B for more information about the organization.) The study team also held discussions/e-discussions with several other key stakeholders to clarify various issues. To develop the case study, we prepared a detailed checklist with 14 broad categories of information and used it while conducting the discussions and interviews. (See Annex C for the checklist.) The key informant interviews were aimed at a better understanding of: (a) operating models and performance of health mutuals, (b) product design and development, (c) characteristics of the mutuals' members and the target market, and (d) key challenges, lessons, innovations, and successful strategies to achieve scale of health mutuals and to cover primary care services.

Findings are discussed in the following sections.

3. MICRO-INSURANCE INITIATIVE AND MUTUAL INSURANCE

Private voluntary health insurance has been in existence for quite some in India. (See Annex D for a discussion of the private voluntary health insurance landscape in India.) This system of insurance does not address the needs of economically vulnerable sections of population. In the late nineties, Dror and Jacquier (1999) described the concept of MI, in which the insurance scheme is voluntary, community-based, and generally managed by self-help groups. This ensured that the design of premiums, benefits, and claims are relevant, attractive, and affordable. To promote health insurance for economically vulnerable populations, the IRDA recognized MI as a special category of insurance in 2005. The regulations of MI products were changed in 2015. (See Annex E for a comparison of the 2005 and 2015 iterations.) The new rules paved the way for larger participation of CBOs in the distribution of MI products, including those offered by cooperatives registered under Cooperative Societies Act, MFIs, and self-help groups (SHGs). Risk coverage limits were raised, taking maximum coverage for health up to Rs 100,000. Also in 2015, for the first time, regulations addressed the commission that MI agents earn for selling and distributing MI products. For health insurance products, the commission is pegged at 15 percent.

The decisions of how to set premiums of MI products lies with insurance companies, and many community-based health insurance (CBHI) schemes use the partner-agent model of selling and distributing insurance products. Commercial insurers sought out partnerships with MFIs and NGOs to act as agents, selling and servicing the insurers' policies. In fact, formal health insurance companies in India promoted these partnerships to expand insurance coverage among the rural poor because it helped them meet their statutory obligation to cover risks of economically vulnerable population groups.

Mutual insurance is not explicitly referenced in the current IRDA regulations of 2015 though the earlier insurance legislation of 1938 recognized mutuals and defined mutual insurance organizations as an insurer having no share capital and all policyholders as members. An early example of insurance based on mutual principles goes back to 1948 when the Calcutta Hospitals and Nursing Home Benefits Association (CHNHBA) was founded through the initiative of the East India Clinic Limited and United Kingdom Citizens' Association. CHNHBA was established as a public company for the purpose of offering medical insurance. The company did not sell its insurance to the general public but rather restricted its clientele, which included top executives of large Indian business companies.

In recent times, the offering of insurance by CBOs on mutual principles, rather than the partner-agent model, has been experimented with in India. In 2003, Annapurna Pariwar was one of the first CBOs to develop and implement health insurance based on the mutual concept. The community/mutual model has been found to be promising for the organization and management of insurance that promises to meet the needs of communities in an effective manner.

4. COMMUNITY/MUTUAL ORGANIZATIONS

A mutual is an autonomous association/organization of legal entities or persons operating in (and sometimes across) different sectors: health care, banking, insurance, and many others (Grijpstra et al., 2011). As the name implies, the primary objective of such an organization is to mutually benefit its members and to satisfy their common needs. The members are also the owners of the scheme/program and are not controlled by outside investors. Since these organizations do not depend on outside capital, they are not exposed to vulnerabilities of investor preferences and capital market fluctuations. Key features of a health mutual are:

- A mutual is owned by and run for the benefit of its members.
- A mutual organization raises funds from its members, and these funds are then used to provide common services to all members of the organization or society.
- Any excess revenue is adjusted by lowering the cost of policies, which keeps the market competitive, or by investing in improving services or supporting their community, as the members decide.
- If a member chooses to terminate a mutual insurance policy, the member also withdraws from the mutual and gives up the rights of ownership.
- Mutuals have a long-term, value-based, and needs-driven approach and work well for all income groups in a society. In particular, they are regarded as an appropriate platform for sustainable poverty alleviation and local or community-based empowerment (ICMIF, 2016).

These organizations – which include mutuals, mutual benefit organizations, cooperatives, friendly societies, CBOs, risk-pooling organizations, and self-insuring schemes – may differ in legal structure, size, membership rights, and scope of activity (Grijpstra et al., 2011). ICMIF has classified this diverse range of organizations in the community space as "mutuals, cooperatives, and community-based organizations" (MCCOs). The main feature that sets MCCOs apart is that they are member-owned and are based on the principles of democracy and solidarity (Access to Insurance Initiative, 2015). These characteristics enable MCCOs to overcome geographic, cultural, business model, service, and product-design challenges that more conventional insurers are either unwilling or unable to deal with, particularly when it comes to serving low-income populations. In addition to most MCCOs being risk carriers, some provide administrative, educational, and distribution services.

MCCOs for insurance operate in most regions of the world today, although they are most common in Europe and North America (ICMIF, 2014). They have a long history, and in fact, some existing mutuals date back to the late 17th century. Mutual insurers were originally set up by socio-economic groups (such as miners, farmers, fishermen, and teachers) in the absence of suitable protection or savings solutions from the mainstream insurance sector (Swiss Re, 2016). In England, friendly societies are believed to be first such societies that attracted the attention of the English government in the 19th century. They were created to provide support in the event of wage losses to co-workers (Mossialos and Thomson, 2004). Gradually, governments and philanthropists took an active interest in their development; with regulatory and legislative help and funding support from philanthropists, these organizations started growing rapidly and diversifying into multiple areas, including health.

More recently, African countries have begun adopting MCCO principles and organization for health insurance (Criel and Van Dormael, 1999). Unlike in Europe, the motivation for these African health MCCOs remains largely external, with donors taking the lead. Since such efforts are resource intensive and subsidy driven, at least during their initial phases, any change in government or donor priorities can challenge their success, scale, and sustainability. Annex F compares and contrasts health mutuals in Europe and Africa since the movement is common on both these continents, which otherwise have varied socio-economic and political scenarios.

Today, MCCOs exist in more than 70 countries. The countries where MCCOs for health and health insurance are present are France, Netherlands, Argentina, United States, United Kingdom, Japan, Belgium, Philippines, and Sri Lanka. Data from 59 countries where health mutuals operate show that there are about 4,961 cooperatives and mutuals engaged in health activity, and about 81 million people use their services (ICMIF, 2014). An estimated 43 countries have cooperatives and mutuals that own and/or manage health facilities such as clinics, medical centers, and hospitals. The cooperative model is prevalent in the pharmacy sector at all levels worldwide, including retail pharmacies, wholesalers, and drug producers (laboratories). Another crucial finding with huge implications for the health sector in India and other developing countries is that services or products provided by cooperatives or mutuals may provide affordable options to large communities (Girard, 2014). MCCOs therefore have potential to play a valuable role by becoming partners with the government in achieving universal health coverage as envisaged by the World Health Organization (Girard, 2014).

5. MCCOs IN INDIA

In India, CBOs may be classified into four groups: (a) NGOs, (b) SHGs, (c) cooperatives, and (d) MFIs (International Association of Insurance Supervisors, 2016). (See Annex G for a description of these organizations, highlighting their differences.) Any CBO can form the MCCO; the MCCOs are registered under societies/trust regulations, company legislation under section 8, or cooperative legislation, or they may be unregistered. An overlap is also observed sometimes across these groups. For example, the Gujarat-based Self-Employed Women's Association (SEWA) is a cooperative that also runs women's SHGs.

Mutual companies for insurance, such as the CHNHBA mentioned in Section 3, existed in India before insurance sector nationalization in 1956 (Bhattacharya and Rane, 2003). Organizations such as SEWA have provided health MI under their social protection scheme since the 1990s (VimoSEWA, 2016). They offer health insurance under the partner-agent model. Recently they have begun to offer started mutual insurance to provide coverage for the loss of wages.

Annapurna Pariwar, founded in 1993 to offer credit services, began to consider setting up a health mutual in early 2000 to cover the health protection needs of its credit society members.[2] It was one of the first community-owned mutual health insurance organizations in India operating in a low-income setting with an ecosystem and risk-mitigation approach. Today, it covers more than 200,000 people.

Mutuals have the potential to play an important role in fulfilling the financial inclusion agenda of the Government of India, especially in health insurance. In a vast country such as India, official figures from IRDA indicate that 447 million people were covered under health insurance as of March 2016. About 76 percent of them (361 million) are covered by government health insurance schemes. Most of the government health insurance schemes focus on families that are below the poverty line and effective utilization of this coverage remains a challenge. At the same time, a significant segment of the population just above the poverty line provides a market opportunity for developing and expanding mutual and cooperative health insurance. It is perhaps the right time to generate data and case studies on the work that existing mutuals are doing and focus on strategies to scale them up.

As mentioned in the methodology section of the report, the pre-release draft of an ICMIF and Indian Institute of Insurance landscape study states that there are about 15 MCCOs spread across 13 states. Most are concentrated in a few states of western and southern India, especially in Maharashtra, Karnataka, and Tamil Nadu, with hardly any in the east and north except for a small presence in Rajasthan. Most of these organizations were founded to offer micro-finance services in the form of credit, pensions, and insurance. They currently provide insurance services, primarily for life, health, crops, and livestock, to about one million people (III and ICMIF, 2016). The research team of this report, however, identified about 20 MFIs offering health insurance, of which 11 fit the criteria for this study. (See Annex A for details about the schemes, including their inception year, location, and membership.) Of the 11, Annapurna Pariwar was selected for a detailed case study.

[2] Further detail about Annapurna Pariwar is available at www.annapurnapariwar.org/

Some of the health insurance products identified operate under the partner-agent model in partnership with commercial insurance companies whereas others use the community-based mutual model. And some NGOs and MFIs have developed a hybrid approach to deal with multiple facets of health needs, given the risks of insurance. For example, SEWA uses the partner-agent model for hospitalization services and mutual model for wage loss.

6. KEY FEATURES AND PERFORMANCE ENABLERS OF HEALTH MUTUALS

Unlike conventional insurance, MCCOs take a member-centered approach in serving their beneficiary groups. Their experience suggests that they are able to garner higher levels of member trust and develop a culture of supporting each other. MCCOs often provide more than insurance. Enablers such as the use of technology, governance practices, and innovation in approach can positively influence MCCO performance and, consequently, sustainability. These enablers and key features, as identified during the field visits and through secondary data and literature review, are discussed below.

6.1 Needs First Approach

Health mutuals and cooperatives follow a needs-first approach to risk amelioration rather than the profit-first approach of a shareholder-driven company model (ICMIF, 2016). Mutual insurers are adept at serving the needs of the poor and underserved. For instance, CARD Mutual Benefit Association in the Philippines and Co-operative Insurance Company Group in Kenya offer services to low-income households, in particular, taking into account their different needs (ICMIF, 2016). Mutuals develop insurance solutions primarily from within communities/societies and not with external players. Mutuals follow a reimbursement model, develop their own informal accreditation of facilities, and negotiate service rates with the various service providers before commencing service provision (for example, Annapurna Pariwar). Due to the members' active involvement in identifying the service facilities that merit accreditation and empanelment, they are aware of the quality of services provided by the facilities.

6.2 Product Design

MI products can be (a) part of the CBOs' efforts to provide social protection to the poor using the mutual route or (b) products offered by health mutuals that take a market-based approach using the partner-agent model (Churchill and Matul, 2012). In the first approach, the MCCOs tend to undertake functions that might not fit their competencies. For example, they assume responsibility for product pricing and design, marketing, and distribution of risk, claim processing, and management functions. If enrollment in a program remains small, this may affect its bargaining power with service providers. At the same time, the absence of partnership with the commercial insurer might bar the mutual from access to the distribution network and other means for scaling up (Koven, Chandani, and Garand, 2013). Annapurna Pariwar has addressed the problem of limited enrollment by making the program compulsory for all members. The second approach considers poor people's numbers as a market segment with huge potential and plays on this scale to ensure that the product is profitable. In such approaches, CBOs act as agents of commercial insurance companies. However, this approach has difficulties that include high transaction and distribution costs, social exclusion, and unattractive insurance coverage. Also, the governance practices that characterize organizations like Annapurna, such as ensuring community-level joint decision making, will be challenging to manage as coverage expands. It has also been observed that low amounts of coverage and high loss ratios among insurers are counterproductive to extending health coverage, financial security, and high renewal rates among the poor in India (Dror et al., 2009).

6.3 Technology

Globally, technology is a game changer with the potential to re-configure the competitive landscape in which insurers operate. Technology is an enabler of scale and efficiency in health insurance; it is bringing down costs, improving service coverage and quality, and helping make interventions inclusive. Annapurna Pariwar uses integrated an information technology (IT) platform for claim management, helping them scale up operations and process data for monitoring and reporting across their portfolio of activities. MCCO insurers recognize the need to innovate, and some are in the process of promoting digitalization through IT in all areas of their operations in order to widen their penetration in the insurance market.

In India, especially in its rural areas and urban slums where much of the population is not yet technologically savvy, MCCOs may face challenges in adopting technology. However, MCCOs such as Annapurna Pariwar have developed simple, user-friendly – and relatively low-cost – technological interventions that their members find easy to deal with. Annapurna has developed an IT system for claim processing and management, and its software has evolved with actuarial support from technical partners. Some health mutual schemes use value-added services such as telephone hotlines for free doctor consultations to enhance their appeal, which currently is limited to inpatient care. In the future, growing development of peer-to-peer insurance platforms may help the groups share risks among themselves. Exploiting social media and smart analytics to improve understanding of customers' needs and preferences should be a natural fit for mutuals given their desire to serve the interests of their members (Swiss Re, 2016).

6.4 Social Capital

Social capital is defined as "networks together with shared norms, values, and understandings that facilitate co-operation within or among groups" (Organization for Economic Co-operation and Development, 2016). Mutuals are member based and their members have common needs and values. Hence, they foster social capital at the community level. Studies in public health have shown that high social capital is associated with higher self-rated health (Kawachi, Kennedy, and Glass, 1999; Rose, 2000), more non-threatening health-related behaviors (Lindström, Hanson, and Östergren, 2001), and lower mortality (Kawachi et al., 1997). A study in China (Zhang et al., 2006) indicates that community-level and individual-level social capital are significantly and positively associated with the probability of farmers' willingness to join a newly developed government-subsidized CBHI scheme. The trust, involvement, and ownership of members are enablers of mutual performance. For example, the Annapurna Pariwar case study suggests that members can play an important role in increasing awareness about the benefits of enrollment and thereby motivate friends and family members to join the mutual and avail themselves of the benefits of health care and insurance.

6.5 Innovations

The environment in which MCCOs operate is more volatile than environments in which commercial health insurers operate. Commercial health insurance companies are clear about their targeted clientele and their needs. Most of their clients have higher ability to pay. In emerging economies, new markets and innovations need to serve the bottom of the pyramid. MCCOs not only have the capacity to innovate and overcome the challenges that health MI schemes face, but they also have the capability to find answers for tough questions as community members constantly watch, evaluate, and support them. For example, health mutuals continually ask questions such as:

a. Are the medical costs for procedures covered under the scheme unattractive and unrealistic?

b. Does the scheme align its products with local health care needs?

c. Is the benefit package and coverage adequate?

Worldwide, there are numerous successful examples of technological, social, or business innovations leading to better health outcomes. An international survey of MCCOs that work in the health and social care sector (Girard, 2014) highlights how MCCOs are strengthening innovations and access. In Peru, coffee and cocoa production cooperatives provide essential care services to populations in the inter-Andean forests. The sector involves more than 50,000 families in 78 coffee cooperatives and 180 small-producer associations. Their health activities had an impact on a very large segment of the population with limited access to health care. Some models are using alternative health cadres that are more appropriate for communities and can act as first referral points and guide pathways of care.

6.6 Preventive, Primary, and Referral Health Care Services

Most insurance and MI schemes run by traditional insurance companies in India do not look at risk mitigation strategies in a holistic manner. For example, most focus on hospitalization and do not include primary care, where health issues can be addressed at an early stage and financial risk is lower. In contrast, many health mutuals have a preventive and promotive focus as well as a curative one, which is important for a vast and populous country such as India and its over-burdened secondary and tertiary care systems. Health mutuals such as Annapurna Pariwar invest in and promote preventive and primary care as they believe such efforts reduce overall claims. Having all community members enrolled in a scheme enables them to promote preventive and primary services to all their members. For example, cooperatives often address problems such as alcoholism in the community. Annapurna Pariwar trains field staff to conduct regular health talks to educate clients and offers a dial-a-doctor service, which provides advice to clients. The clients have access to low-cost outpatient services and medicines from a panel of more than 300 outpatient clinics and pharmacies with which the mutual has negotiated discounts. Annapurna also organizes health camps and suggest pathways of care when members are in need. There are examples from other countries as well: in France, Harmonie Mutuelle has created an impressive network of clinics, hospitals, day-care centers, etc., in addition to providing health insurance. In the United Kingdom, Benenden Health and the public authority operate under an arrangement whereby the mutual provides complementary health insurance and owns a hospital (Girard, 2014).

Health mutuals can provide 24x7 referral guidance to their members about which facility to use when they fall ill. They also provide members with information on their diagnostic assessment. For example, Annapurna Pariwar provides a 24x7 helpline for members seeking hospitalization.

6.7 Awareness Generation

The idea of health insurance is relatively new to the poor in India. Basak (2013) identifies lack of insurance awareness and limited trust in agents and insurance companies as reasons for the poor penetration of schemes. MCCOs are largely community based, and since they already work on the basis of cooperation and trust, they are likely to have an advantage over most government health insurance schemes (GHIS) in building awareness and trust and developing social capital around health insurance. Annapurna Pariwar conducts awareness generation activities to inform the community about the benefits of insurance. Also, since the family pays the full premium, there is a greater chance that they are aware of the scheme's benefits. Under the mutuals model, MI is part of a wider process of empowerment and education (especially for the poor and underserved) and not merely a part of the development of an effective market economy (ICMIF, 2016).

6.8 Governance

While many MCCOs are committed to good governance as an indicator of their strength to survive in the evolving global economy, the challenge for them remains to find a balance between good governance and their unique characteristics. Even though profits are not their motive, MCCOs, like other businesses, need to be financially viable. But due to their being member-driven and owned, they take a different approach to governance, structure, ownership, investment, and disposition of surplus. Annex H defines governance and the components of good governance that mutuals must adopt.

Our case study of Annapurna Pariwar suggests that the organization has a board that has made rapid business decisions such as investing in the latest technology while not ignoring its members and maintaining member proximity. MCCOs face growing pressure to compete and to be innovative in growing their business base with appropriate branding, since today's consumers are presented with more options than ever in an increasingly global economy. MCCOs want to remain competitive through a responsive governance structure.

To conclude, the above discussion shows that cooperatives and mutuals bring many values to a society and also build social capital. They bring choice to their members and offer competitive services with a long-term perspective and good governance principles. With relatively low premiums and benefits selected by the members to match their needs, they are suitable for all members of society, regardless of their economic status. In fact, in low- and middle-income countries, risk pooling remains an important mechanism for individuals or families who otherwise must cover the cost of basic services out of pocket. MCCOs can play an important role in the achievement of universal health coverage.

7. PERFORMANCE OF MCCOs IN HEALTH INSURANCE

One of the key performance indicators for MCCOs is how much they help increase use of health services by lowering financial barriers. There is scant literature globally on MCCO impact and long-term viability, in part because MCCOs are a relatively new concept. With regard to OOP spending, findings are mixed, with some studies suggesting positive MCCO impact, while others suggest no impact or limited benefits. Moreover, findings differ from country to country.

A study in the Philippines showed that insured persons reported higher utilization of health services in micro-health insurance schemes (Dror et al., 2005). An indirect but positive outcome seen in a survey by Bauchet et al. (2010) of facilities empaneled with community MI schemes in India was that those facilities achieved more care-related benchmarks than did non-network facilities.

In a study of health mutual funds in Kenya, Uganda, and Nigeria, Ransom (2016) found that although outright dissatisfaction with health mutual funds was not reported by anyone, complete participant satisfaction was limited to only one country. This was linked to the management challenges faced by the health mutual, including high caregiver expectations, long waiting periods, and hurdles in meeting needs for the very sick. On the question of prospects of the mutuals, the author found a desire for greater expansion and caregiver involvement and scope for creative institutional arrangements such as merging health mutual funds into a woman's bank.

Factors that lead to success or failure of CBHI schemes were found repeatedly in Nigeria and other African countries. Problems were predominantly operational and included the failure to consider the inability of the target population to pay premiums, the absence of a clear legislative framework, a lack of financial support, and systematic inefficiencies in membership requirements (Odeyemi, 2014). However, Ghana, Rwanda, Cameroon, and Tanzania present interesting examples of countries where challenges have been overcome, and mutuals been made an effective means of health care delivery (see Annex F).

In India, the health MI scheme offered by Annapurna Pariwar reimburses inpatient cost. There are challenges in a reimbursement model. Currently members have to bear the financial risk for about two months before they receive reimbursement under the mutual insurance program.

We need systematic reviews to study the performance of MCCOs. Habib, Purveen, and Khuwaja (2016) argue for the need for a systematic evaluation of the impact of health MI schemes run by MCCOs. They found that no impact evaluation has been undertaken though more than 100 health mutual insurance schemes are operating in low- and middle-income countries such as India and sub-Saharan African countries.

8. CHALLENGES FACED BY MCCOs IN INDIA

MCCOs face multiple challenges to sustaining and scaling up their operations. This is largely due to the regulatory environment, product offerings, and lack of awareness about them in the community. This section discusses the main challenges that Indian MCCOs face.

8.1 Regulatory Environment

The absence of IRDA regulation of MCCOs presents a challenge for their recognition and scalability in India. As outlined in the International Association of Insurance Supervisors Issues Paper of 2010 on the Regulation and Supervision of MCCOs, MCCOs' member-based nature raises a number of issues that may require a dedicated regulatory and supervisory response.

With the passage in 2005 of the IRDA Insurance Act and the Rural Social Sectors' Obligations Act, the Indian MI landscape changed for the better (Roth et al., 2005; Sa-Dhan, 2014b). Based on these regulations, the formal commercial insurance companies promoted the partner-agent model, helping to expand health insurance coverage among the poor in rural and urban areas.

While the IRDA has created a special category for MI policies to promote insurance coverage among economically vulnerable sections of society, the IRDA regulations make no mention of mutuals. It recognizes only the following as distributors of insurance products: NGOs, SHGs, MFIs, Reserve Bank of India (RBI)-regulated non-banking financial companies, district cooperative banks, regional rural banks, urban co-operative banks, primary agricultural cooperative societies registered under the Cooperative Societies Act, and Business Correspondents who have been appointed in accordance with the RBI Financial Inclusion Guidelines.

Policymakers are gradually recognizing the role of MCCOs. Financial inclusion strategies now emphasize health insurance and recommend creating health mutuals and making provisions for reinsurance (Dasgupta, 2009). There is an urgent need for regulations that can address and balance the three competing objectives: coverage, costs, and affordability (Saha, 2012). Mutuals can help address all three objectives.

The new risk-based regulatory capital standards (globally) could put some organizations at a competitive disadvantage compared with better-diversified insurers. A possible solution to this could be a focus on the range of capital solutions available to a mutual, including, as has happened in some countries, new legislation for the issuance of mutual-specific capital instruments. Reinsurance, collective access to reinsurance, and alternative risk transfer mechanisms such as insurance-linked securities can also provide mutuals with increased financial flexibility to cope with unexpected losses, expand their business, and compete with other types of insurers (Swiss Re. 2016). However, reinsurance is often perceived as more expensive than other forms of capital.

8.2 Solvency Regulation and Governance

Globally, the enhanced solvency regulation and tougher corporate governance arrangements can pose a challenge to some aspects of the MCCO business model. For example, the regulatory requirement of having capital base of Rs 100 crore (about US$15.4 million) as a solvency requirement for all types of organizations is a serious entry barrier. Small mutual insurers in particular feel that that compliance with these measures could create a financial, administrative, and operational burden that impairs their ability to survive. Moreover, as discussed in Section 6, while many MCCOs are now committed to good governance as an indicator of their strength, the challenge of balancing good governance and the unique characteristics that mark the cooperative model is enormous. The lack of scrutiny by external investors means that mutuals can be vulnerable to managers who are driven by self-interest rather than by the goal of promoting the benefit of members (Greene and Johnson, 1980).

8.3 Scaling-up Challenge

Expansion holds the key to sustainability. Annapurna Pariwar has adopted strategies to expand its membership base to achieve economies of scale. There are many demand-side, supply-side, and structural factors determining scale-up. A recent study conducted in Kerala pointed out that the major demand-side factors affecting enrollment in health insurance schemes were socio-economic status, cultural practices, access to health facilities, and awareness about the schemes. The supply-side factors are the availability of attractive insurance products, policies that determine the ease of reimbursement, and sustainability of the available schemes. Another factor is adverse selection, i.e., unhealthy people want to enroll and are more likely to buy health insurance than are healthy people if insurance remains voluntary (Basak, 2013; Dror et al., 2009; Ashta, 2013; Michielsen, Denny, and Chaudhuri, 2009; Sheshadri et al., 2014). Structural factors in the case of Annapurna are that it does not sell to non-members, and the competition in credit market which constrain its scalability. It needs to resolve these issues.

At the same time, Annapurna also challenges the notion whether it is always good to scale-up. Some studies have shown that smaller mutuals have much lower loss ratios than larger ones, possibly because small mutuals are much more focused on personal insurance (A.M. Best, 2012). Furthermore, they have a close relationship with their members, enjoy more loyalty, and may be better able than their larger peers to assess risks and price accordingly. Annapurna believes that affinity among members within a small mutual might also help to reduce fraudulent or exaggerated claims. On the other side, there are economies of scale associated with claims handling and policy management that small schemes may not have. Resolving these trade-offs is a key managerial challenge.

9. A CASE FOR PARTNERSHIP BETWEEN MCCOs AND GHIS

In India, the development of GHIS signals a shift in policy by systematically channeling public funds to large, organized risk pools for families living below the poverty line. However, GHIS and commercial insurance schemes do not cover the entire population. So, to expand coverage, especially for MI, MCCOs may be a good complement to existing schemes.

First, MCCOs, which have an ability to connect with the communities, have developed a comprehensive approach to health care based on the needs of their members, including a focus on primary health care. GHIS, on the other hand, are designed to protect beneficiaries from catastrophic costs and largely only cover hospitalization costs. The GHIS interventions do not include consultations, medicines, and diagnostics expenditures on non-hospitalization needs. The result is a disproportionate increase in tertiary care expenditures (Shahrawat and Rao, 2011). Sengupta (2013) points out that this inpatient focus excludes treatment for almost all infectious diseases such as tuberculosis and chronic illnesses such as hypertension, heart problems, diabetes, and other interventions that need continuity of care appropriate for an outpatient setting. MCCOs can design their benefit packages in a way that supplements the benefit packages of GHIS and other schemes. For example, MCCOs could cover outpatient expenditures while GHIS could provide inpatient treatment. This would be extremely useful in bringing down OOP expenditures on health care.

Second, GHIS and other government-funded schemes are usually designed so that the government subsidy can be targeted to the formal sector or to poor and vulnerable families, especially those below the poverty line. However, a recent study on socio-economic determinants of participation in GHIS found that because of lack of awareness and poor targeting, districts with greater numbers of socio-economically disadvantaged groups are less likely to have people enrolled in the government scheme (Nandi, Ashok, and Laxminarayan, 2013). Also, a large number of Rashtriya Swasthya Bima Yojna (RSBY) smart cardholders (40 percent) have not used insurance to pay for treatment due to the many barriers like lack of awareness about insurance, lack of knowledge about the empaneled hospitals, long distance to hospitals, denial of treatment by hospitals, or service providers discouraging use of the smart card. Another study found evidence of RSBY beneficiaries paying money upfront before, during, and after treatment. The proportion of RSBY beneficiaries paying OOP was found to be higher among vulnerable groups such as scheduled castes than high-caste beneficiaries (Sabharwal et al., 2014).

MCCOs can target better as they are part of the communities they serve. Moreover, they are not limited only to clients living below the poverty line and can therefore enroll families that are otherwise left out of GHIS. This would fill a gap in much-needed population coverage, particularly for those living just above the poverty line.

Third, MCCO-GHIS collaboration would give MCCOs access to economies of scale otherwise available only to government schemes. Such a linkage, if properly designed and integrated, would benefit both public and non-government partners. This would enable greater population coverage and use of the existing micro-finance network developed by the MCCO sector for distribution and enrollment in the GHIS. MCCO schemes will get legislative or regulatory advantages and access to negotiated package rates, IT systems, monitoring systems, and a larger network of empaneled hospitals. This has not been tried formally but could bring efficiency to the health system while increasing the possibilities of scaling up and sustaining Indian MCCO health insurance schemes. It will ensure development of better health insurance market functioning based on the principles of complementarity and cooperation between government and MCCOs.

10. BUILDING ON EXISTING AND POTENTIAL LINKAGES

Most MCCOs build on existing linkages. Health mutual insurance has never been the sole purpose or stand-alone project of an MCCO. MCCOs are mostly cooperatives for agriculture or sustainable development like Shri Kshethra Dharmasthala Rural Development Project (SKDRDP), MFIs such as Annapurna Pariwar, and SHGs of women as in the case of SEWA. Health insurance mutuals have been set up in response to the perceived need to protect members' health and reduce their catastrophic OOP expenses on health care.

It is well known that in community financing schemes, the participation of all segments of the community is not automatic. Making participation happen requires resources of time and money, which the most disadvantaged groups in society often do not have. For example, a study showed that a household belonging to the bottom quintile, the poorest of the poor, is less likely to enroll in the scheme; distance to health services or enrollment in the scheme still are access-related issues (Sheshadri et al., 2014). To promote schemes and to lower access barriers, well-targeted subsidies and a linkage to the social fund are possible solutions (Jütting, 2004).

Even if barriers such as upfront admission fees or transportation costs do not exist, the loss of daily wages; paying forced tips and bribes; irrational (unnecessary) treatment, tests, and prescriptions; and referrals to expensive practitioners are other, strong financial barriers to enrollment. In addition, non-financial barriers limit the effectiveness of simple market mechanisms to improve access to quality health care (Michielsen, Denny, and Chaudhuri, 2009). These barriers include lack of information about where to find reliable and quality treatment, social exclusion due to low status (especially for women), and discourteous treatment by service providers during medical encounters.

Despite the good intentions of the central and state governments, the factors discussed above continue to be the key reasons health protection schemes do not succeed in providing health care to all. The answers to problems of coverage, costs, and affordability of health care lie to a large extent on the untapped potential of health mutual. They can work either on their own or through a public-private partnership model to serve health care needs and provide alternate risk protection for health care.

10.1 Exploiting Technology

There is a need to start connecting various mutual initiatives to improve their efficiency and sustainability. Technology enables products and processes that insurance providers can use to improve their operations and to scale up at minimal cost. Experience shows how MCCOs can implement affordable technological innovations. They can pool their resources to agree on one IT platform. They can even potentially share risk with each other. Use of technology can be vital for awareness building, marketing, enrollment, renewals, premium collection, and claim settlement. For example, using mobile phones and automated teller machines for premium collection can keep transaction costs low. Muniraju and Jayasheela (2014) show that a strategic perspective toward MI together with innovations in technology and assessment of client demand are the keys to the future of MI in India. While there is still a question about the extent to which technology can replace participatory interactions that have been at the core of the micro-finance philosophy since its inception, technology presents significant opportunities to gain efficiencies and improve the quality of information and services.

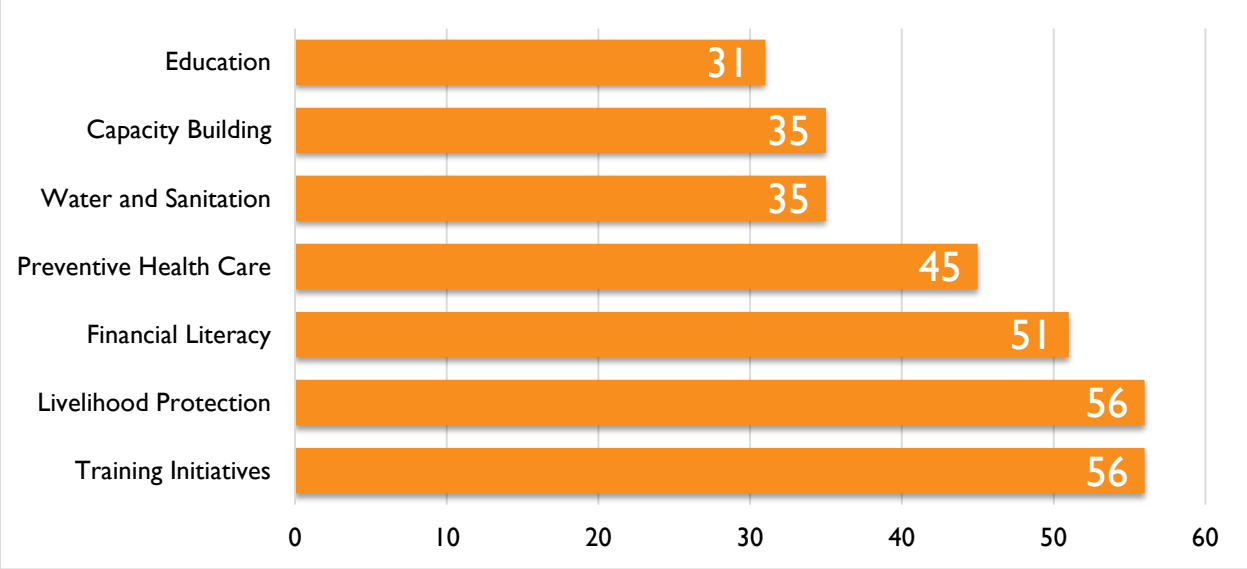
10.2 Benefiting from Growth of Micro-finance Institutions

Micro-finance in India started in the 1970s with the emergence of informal SHGs as an alternative source of finance. They provided access to much-needed savings and credit services to the underserved masses at the bottom of the socio-economic pyramid. Over the years, micro-finance has become a tool for lifting people's economic standards and working their way out of poverty. The sector witnessed strong growth following the liberalization of the Indian economy in 1991. Between 2005 and 2010, the micro-finance sector reported strong growth; however, in 2010, the sector was severely impacted by the Andhra Pradesh crisis (EY and Assocham, 2016) and that state's government promulgation of an ordinance to curb the activities of MFIs. The crisis triggered a strong response from the RBI, and in the years that followed, the sector has registered a turnaround and has evolved into a more mature market (EY and Assocham, 2016).

MFIs currently operate in 28 states, 5 union territories, and 568 districts in India. Karnataka, Tamil Nadu, and West Bengal lead in client outreach and portfolio. According to the directory of MFIs in India (Sa Dhan, 2014a), there are 268 MFIs. According to the Bharat Micro-finance Report 2015, the total membership base of MFIs in India is 37 million. Together they have 12,221 branches with a total staff of more than 94,500, of which 16 percent are women (Sa-Dhan, 2015). Policymakers and regulators recognize the pivotal role these institutions play in expanding financial inclusion to the unreached and under-reached segments of the population. Many of these institutions have developed and implemented health insurance programs using the community/mutual model or partner-agent model. These health insurance programs provide coverage from catastrophic OOP expenditures on health to members and their families. This sector can be a good aggregator of clients, thereby reducing the administrative cost of managing a health insurance program. It has a potential to reach 150 million members of communities. According to the Bharat report, there are approximately 101 million families associated with SHGs.

The various development activities the MFIs are engaged in today are shown in Figure 1. About 45 MFIs are involved in preventive health care activities.

Figure 1: Development Activities of MFIs



Source: Sa Dhan (2015)

The Bharat Micro-finance Report further indicates that 21 MFIs have reached out to 4.06 million clients to provide health MI. By addressing demand-side barriers, the programs address supply-side barriers. To succeed, it is important that the programs engage and strengthen social capital among members. Saha and Annear (2014) caution that micro-finance-based solutions cannot be seen as the sole contributor to poverty reduction or as an alternative to government intervention. Also, any MFI-based community health programs need time to mature.

Extending health services through micro-finance is associated with improved health awareness, behaviors, and health outcomes. Therefore, it is important to build MFIs' interest in and willingness and technical capacity to offer health programs along with their financial services. Their ability to reach the most remote areas is worth a modest investment in capacity building (Leatherman et al., 2014).

Trust and familiarity seem to be a necessary condition, though not the only one for achieving broad-based voluntary affiliation to MI schemes. Trust, familiarity, and social capital can be enhanced by the interaction of the community with a solidarity-promoting health MI organization (Dror, 2010).

Through efficient business models, benefit packages tailored to suit client needs, and multiple payment plans, health MI programs can seek a balance between reducing financial vulnerability and improving health outcomes. Unlike traditional insurance, which is based on providing financial security, health MI clients want to see improved health outcomes from their investment (Leatherman et al., 2010).

10.3 Collaborating with Cooperative Structures

As discussed earlier, India has a network of more than 600,000 cooperatives with a membership of 250 million. The Indian Cooperative Movement has played an important role in the Indian economy, especially in the development of the agriculture and rural sectors. The movement combines the strengths of both the public and private sectors, especially in supporting small and marginal farmers and weaker sections of the population. Post-independence, the cooperative sector was recognized by the government as the third economic sector to serve as a balancing factor between the private and public sectors (Kumar, Wankhede, and Gena, 2015). Different types of cooperative societies are operating in India with different activities.

Mutual health insurance can significantly benefit from collaborating with cooperative structures, such as dairy cooperative AMUL and the global fertilizer cooperatives IFFCO and KRIBHCO. Their outreach and accessibility in every corner of the country and contact with the community can enable health insurance delivery through the mutual or partner-agent model by the cooperatives themselves and even by public and private providers. SEWA's work in this area has received global acknowledgment and appreciation. The government of Karnataka's health care scheme, called Yeshasvini Cooperative Farmers' Health Care Scheme, is a well-known example of a public-private partnership. It is critical to tap the capacity of many cooperatives to deliver health care services and do financial risk pooling. Partnership models can address cooperatives' limitations, such as limited resources, poor technology, inefficiency, and weak human resource development policies (Verma, 2009).

10.4 Collaborating with Micro, Small, and Medium Enterprise Clusters

The micro, small, and medium-size enterprise (MSME) sector contributes enormously to India's socio-economic development and has emerged as an important part of the economy over the last five decades (Ministry of MSME, 2016). Thirty-six million MSME units employ more than 80 million persons at comparatively low capital cost. Their production of more than 6,000 products contributes about 8 percent to gross domestic product, 45 percent of the total manufacturing output, and 40 percent to exports (Ministry of MSME, 2016). By helping the industrialization of rural and backward areas, they reduce regional imbalances and more equitably distribute income. The MSME sector has the potential to spread industrial growth across the country and can be a major partner in the process of inclusive growth.

The India Small and Medium Enterprise Forum, formed in May 2011, is India's largest small and medium business movement, formed to propel the movement across the country. Today, the forum has more than 76,000 MSME members, 270 sectoral and regional associations as supporters, and 35 major banks, corporations, and organizations as partners (SME Forum, 2017). Such significant outreach has great potential to deliver if it can be sensitized to the need to have a health protection mechanism such as a health mutual insurance system in place for its members.

10.5 Targeting Urban Labor Markets and Migrant Clusters

Urban labor markets have grown over the years. There are more than 100 million migrants in urban areas in various parts of the country, the result of economic growth and the need for labor. In seven selected million-plus urban agglomerations, migrants represent more than 40 percent of the population (Bhagat, 2012). Migration contributes significantly to overcome labor demand and supply gaps and is a source of remittances to migrants' home towns. Return migration, which transfers knowledge, skills, and innovations, is an informal process of skill development (Bhagat, 2012). However, the health and financial protection of migrants is a challenge. Urban planning in various places fails to provide for migrants' health and financial protection. Certain infectious illnesses are quite common among migrants. Many of these illnesses, such as tuberculosis, require continuity of care. Developing insurance products based on MCCO principles may be an opportunity to do this.

In sum, with more than 268 MFIs, 600,000 cooperatives, 36 million MSME units, and several urban migrant clusters, MCCOs can use these networks to scale up and create an ecosystem to reduce OOP expenditures on health.

11. SUMMARY AND THE WAY FORWARD

Based on the principles and practices of mutual organizations, health insurance has a potential to contribute significantly to the financing of, and thus access to and utilization of health care in India. Unlike commercial health insurance, the primary motive for health mutuals is the health insurance needs of their members and ensuring that product design is considerate, need-based, affordable, and attractive. The majority of Indian MCCOs cater to low-income people. Hence their products take their clientele needs and purchasing power into account. In addition to being effective and useful, the offerings have to be sustainable. Efforts throughout the world offer varieties and innovations but their main lesson is on the sustainability of community-based health MI schemes. Since mutuals do not depend on capital support from outside, they exist so long as members feel that their needs are being met. While considering a product or a scheme for scalability, it is helpful to analyze its strength and opportunities (Koven, Chandani, and Garand, 2013). The mutual model seems to have good potential if MFIs, SHGs, cooperatives, micro enterprises, urban labor markets, and MSMEs are leveraged.

This report discusses prerequisites that a mutual health scheme must take into consideration so that it offers products that are appropriate for the markets they want to serve. These prerequisites can potentially dictate the success of those products or schemes. It is important to determine how best a product can address access barriers by removing systematic irregularities like voluntary group enrollment and irregular cash flow of the households, and identity proofs for enrollment.

The majority of existing products cover inpatient care only. It will be increasingly necessary for health mutuals to cover outpatient care. Though outpatient costs can vary significantly, for the majority of poor patients even these costs, particularly of drugs and laboratory tests, can prove catastrophic. While mutuals can cover certain costs on their own, because of their design, it is not expected to be sufficient. Government interventions such as offering free essential drugs, promoting generic drugs, and improving logistic management, pricing, and quality control will continue to play an important role in controlling OOP costs associated with medical care. However, to survive, MCCOs need to keep administrative or operational costs as low as possible. This can be done through distributing fixed costs over a large membership base.

Innovation drives markets and expands outreach. It is vital that low-premium products such as health mutuals and MI invest in innovation and find new ways to increase scale. As business corporations and civil society organizations' interests and capabilities converge, they together can create innovative business models that help new markets grow. There are NGOs, SHGs, MFIs, cooperatives, MSMEs clusters, and urban labor markets that have potential to create large distribution networks that can distribute insurance products. These CBOs have developed a deep understanding of local cultures and consumption habits. In this kind of relationship based on the interdependence of CBOs and companies, both leverage assets and competencies to promote insurance and create greater value.

Health mutuals can be effective in providing health protection to the masses – poor and not so poor alike. Market and government can both provide impetus to the scale-up of MCCOs and can benefit in return from a complementary relationship. MCCOs, on the other hand, still face challenges such as running in-house technical operations that might not be within their competencies, offering products that are viable and attractive, and making their operations sustainable. Using various measures to contain costs is one successful strategy that MCCOs can focus on to lower claims and achieve sustainability. Scaling up health mutuals work would require information about operations, finance, product design, and addressing structural factors.

Mutual organizations can be vital in reducing vulnerability through tailored products such as health loans and insurance, which provide financial risk protection. We conclude that careful product design, cost control, and resource maximization, innovation, and complementarity in relations between the market, government, and MCCOs are vital in scaling up mutual health work in India. To find cases for scaling up mutual health work, information will be required on a case-by-case basis. Nevertheless, the contextual knowledge and information that this review provides should come in handy and complement any such individual case analysis.

ANNEX A: COMMUNITY/MUTUAL BASED HEALTH INSURANCE IN INDIA

	Organization	Product Details	Start Year	Area	Members
1	Development of Humane Action Foundation	Community Health Insurance Program	2003	Madurai and Salem, Tamil Nadu	73,217 households (2.5 lakh individuals)
		People Mutuals	2003	Tamil Nadu and Andhra Pradesh	4.7 lakh mutual contracts
2	Uplift India*	*The information about Uplift Mutuals can be accessed at http://upliftmutuals.org/About-Us.html (accessed December 15, 2016) and in Uplift Mutuals. 2015. Setting up Mutuals: Uplift's Built Operate Transfer License Model, http://healthmarketinnovations.org/sites/default/files/UPLIFT%20MUTUALS%20INFO%20JAN%202015.pdf (accessed October 6, 2016).			
3	SEWA	VimoSEWA	1992	Across India	1,95,472
4	Annapurna Pariwar	Community-owned insurance program	2003	Maharashtra	1,91,762
5	SAS Poorna Arogya Healthcare	Sudhananda Poorna Arogya Scheme (SPAS)	2010	Karnataka	1,47,000
6	Basix India	Basix Health Insurance	2001	Across India	5,25,000
7	SKDRDP	Sampoorna Suraksha Health Insurance	2004	Karnataka	721,130* inclusive of Jeevan Madhura Life Insurance which is not a HM
8	Grameen Koota	Coverage of Rs 6,000	2010	Karnataka, Maharashtra, Tamil Nadu	280,000
9	ACCORD	Adivasi Mutual Health Insurance Program	-	Tamil Nadu	15,819
10	PEDO		1995	Dungarpur, Rajasthan	17,000
11	Shepherd	Community Mutuals	1995	Tamil Nadu	20,017

S. No.	Organization	Product Details
12	BAIF	Coverage of Rs 5,000
13	Jowar Rural Health Insurance Scheme	Jowar Rural Health Insurance Scheme
14	Charutar Arogya Mandal	Krupa Arogya Suraksha

*At the time of this review, other organizations such as Chaitanya, Navnirman Samaj Vikas Kendra, Parvati Swayam Rojgar, Premseva Mahila Credit Cooperative, Sai Microfinance, Swabhiman Antoday, Swayam Sikshan Prayog were offering mutual-type products in partnership with existing mutuals. For example, Premseva Mahila Credit Cooperative (Mumbai) and Sahjeevan Mahila Credit Cooperative Society in Mumbai are partners of Uplift Mutuals, information about which is available at http://upliftmutuals.org/Partner-Organisations.html (accessed on 22 September 2017).

Table prepared by Dr. Somen Saha based on information collected from various sources (websites, reports, and meetings with stakeholders working with health mutuals and in the field of microfinance).

ANNEX B: PROFILE OF ANNAPURNA PARIWAR

Annapurna Pariwar

Annapurna Pariwar is a group of five organizations aiming to empower poor women by providing services in credit, health, and education. Dr. Medha Patkar, a banking professional, left her regular job to start working in slums of Pune and founded this organization in 1993. The five organizations of Annapurna Pariwar are: (a) Annapurna Mahila Multistate Cooperative Credit Society, (b) Annapurna Pariwar Vikas Samvardhan, (c) Vatsalyapurna Service Cooperative Society, (d) Annapurna Mahila Mandal, Pune and (e) Annapurna Mahila Mandal, Mumbai. Their primary activities are, respectively, credit, health insurance, day-care centers, research and training, and running a working women's hostel.

The health mutual insurance program is run by Annapurna Pariwar Vikas Samvardhan (APVS). APVS is registered as a Section 8 Company. In starting a health insurance program, Annapurna Pariwar was influenced by the fact that it already had a well-functioning credit program that gave it the advantage of knowing its members and the communities it worked with. The fortnightly credit group meetings with members provided information about the members' background, their needs, and the conditions they live in. Annapurna found that members faced difficulties as a result of a high incidence of illness; these difficulties sometimes affected their ability to meet credit repayment schedules on time. In addition, their associated high OOP expenditures on health care were a huge financial burden that sometimes led to their impoverishment. To mitigate these consequences of high OOP expenditures, Annapurna decided to develop and implement APVS to protect its members from the financial risk of hospitalization.

APVS uses a reimbursement model. Participation in it is compulsory for all Annapurna borrowers. By March 2016, the program had issued 50,360 policies and covered 191,762 members. Since 2011, the program has had a compound annual growth rate of 15 percent in membership.

Sources of information:

- Discussions/e-discussions with officials of the Annapurna
- Websites: www.annapurnapariwar.org

ANNEX C: KEY INFORMANT INTERVIEW CHECKLIST

A list of parameters was prepared by the team to facilitate conducting key informant interviews (KIIs). The purpose of these KIIs and subsequent case study development was to gather information in support of developing a blueprint for scaling up mutual-based health insurance. KIIs were designed to understand:

- Operating models and performance of mutuals
- Product design and development
- Characteristics of members and the target market
- Key challenges, lessons, innovations, and successful strategies to achieve scale of health mutuals and to cover primary care services.

To ensure consistent and focused data collection during the KIIs, the team developed an interview guide. Questions in the guide were grouped into 14 broad categories to ease analysis and interpretation of the data collected. The 14 categories are:

- **Background Information about the mutual (7 items):** To develop a case study, it is important first to gather basic facts about the organization under study, such as its year of inception, its scope of work, its parent company if any, benefits it offers to members under the mutual scheme, and ways in which it manages risks and finances.
- **Governance (8 items):** Good governance is required to increase accountability of the mutual and prevent problems. In the absence of regulations for mutuals, governance mechanisms are all the more significant. Questions in this category attempt to understand things like the governance structure of the mutual, members' roles in governance, and the presence of audit and other committees and the board of directors.
- **Demographics (Target Market and Members) (7 items):** These questions summarize basic facts about the members such as age, occupational status, education, OOP spending on health care, and the target market. They help assess health risks and the demand for insurance.
- **Social Capital (4 items):** Research has shown that willingness to join a scheme depends largely on the trust that people have in the scheme and the organization implementing it. The trust and reciprocity that communities feel for each other affects the outreach and sustainability of the mutual. Therefore, questions in this category focus on issues of trust, fairness, and identification of the members with each other and the scheme.
- **Cultural Beliefs/Behavioral Aspects (2 items):** Review of literature shows that behavioral aspects and certain cultural beliefs determine uptake of insurance products. Questions in this category aim to understand what cultural beliefs and behaviors, if any, influence the demand for membership in a mutual scheme.

- **Enrollment and Awareness Generation (13 items):** Questions pertaining to enrollment focus on the target population, specifically who enrolls and who does not, and why, and the enrollment process, eligibility criteria, identification of beneficiaries, unit of enrollment and so forth. These questions have a bearing on membership size, characteristics, and scheme viability. Questions related to awareness generation aim to understand the marketing and awareness generation activities of the mutual. Outreach and expansion of services is affected by the success of the marketing strategy.
- **Product Design and Features (27 items):** Questions in this category assess value for clients and scheme viability. They probe product design features, such as whether the scheme is cashless or reimbursement-based, and the benefit package, especially the primary health care benefits and health care prevention and promotion activities offered. This has a bearing on the claim ratio since insurers may experience fewer and less costly claims and achieve better health outcomes if there is a focus on health care prevention and promotion activities.
- **Product Pricing and Premium Collection (10 items):** Questions focus on finding out about the method the mutual uses to decide on the premium costs, pricing approach, process followed for revising benefits, and whether the pricing is competitive, especially in comparison with social insurance schemes of the government.
- **Use of Technology (6 items):** Technology is an enabler of scale and efficiency in health insurance and can help reach excluded groups. It also helps reporting and monitoring functions. These questions seek to understand how the mutual has used technology and for what purpose. Insights will also be gained into who the technology partners are and what innovations have been used.
- **Key Performance Indicators (KPI's) of the Mutual (11 items):** KPIs have implications for scaling up and sustainability of the mutual. Therefore, these questions focus on the performance indicators about membership and the mutual.
- **Claims (17 items):** Claim processing is another crucial area affecting the success of mutuals. Cashless mechanisms, whereby providers are paid directly on behalf of clients for authorized claims, enhance client value by overcoming the significant financial barrier for clients of having to pay for services when rendered and to seek reimbursement through a retrospective claim process. If the claim procedures are tedious and not well designed, or too many claims are rejected, renewals may decrease, and providers may not be willing to participate. A claims management process with adequate controls helps to safeguard against fraud and manage administrative costs.
- **Health Care Providers - Service and Quality (14 items):** People are more likely to buy insurance if they are satisfied with the quality of service of the empanelled service providers and if access to these providers is easy. Questions in this category focus on how the mutual empanels providers and ensures clinical quality, as well as service quality as perceived by clients (e.g., waiting time, no stock-outs). Quality measures influence demand and trust in and reputation of the scheme.
- **Regulations and Enabling Environment (5 items):** The IRDA of India does not yet recognize mutuals as an MFI. Questions in this category aim to understand how the organization manages to function with such a limitation and if this deters scalability.
- **Sustainability (4 items):** Virtually all of the factors above influence sustainability of a mutual. Questions in this section aim to understand overarching challenges to sustainability, including the effect of government schemes such as RSBY on mutuals. They also attempt to gain insights into the interventions the mutuals have used to achieve scale.

Checklist of Information for Understanding and Evaluating the MCCOs

1. Background Information about the Mutual

About the organization

1.1 Years the MCCO is in existence

1.2 Year of establishment of parent organization, if any

1.3 Name of the parent organization

1.4 Key activities of the organization – products, services, etc.

1.5 Key benefits given to the members under the mutual scheme

Risk management

1.6 How does the mutual manage financial risk? Describe any reinsurance mechanism – to what extent would greater risk transfer help the organization scale up?

1.7 How does the scheme ensure adequate working capital?

2. Governance

2.1 What is governance structure of the health mutual?

2.2 Can you share information about the role of members in governance?

2.3 To what extent do members participate in scheme operations (e.g., do they participate in claims committees?)

2.4 Do you have a board of directors to guide various aspects of functioning of the mutual?

2.5 Do you have any female members on the board?

2.6 Do you have an audit committee? If not, who does the audit?

2.7 Do you bring out annual reports and post them online to share your performance and financial condition?

2.8 Who oversees the financial and risk management practices in your mutual?

3. Demographics (Target Market and Members)

3.1 What is the average age and age range of members?

3.2 What is the proportion of female members?

3.3 What is the average family size of members? (joint or nuclear family)

3.4 What is the educational status of members? (mean and range)

3.5 What are the key occupations?

3.6 What is the average (range) annual income, income distribution, and income pattern of members? (timing, frequency, seasonality, predictability)

3.7 What is the average (range) OOP for healthcare of members? Some broad ideas.

4. Social Capital

4.1 How can you know if members have trust in the insurance scheme and its management? In what ways can you determine this?

4.2 Can you share instances to show how members identify with the mutual? (sense of belonging)

4.3 Do group members perceive that other members will not make false claims? How can you say so? (perceived social responsibility)

4.4 Is there a sense of fairness perceived towards the scheme? How are the decisions taken by the group?

5. Cultural Beliefs/Behavioral Aspects

5.1 Which behavioral/cultural beliefs have you come across in the communities that you work with that hamper participation/enrollment? (e.g., take out an insurance policy in anticipation of health problems in the family)

5.2 How do you overcome behavioral and cultural barriers to enrollment? For example, it's a fact that low-income households struggle financially and that they are unlikely to prioritize insurance. How do you change such behavioral issues?

6. Enrollment and Awareness Generation

Enrollment

6.1 Who are the population groups that are eligible/targeted for enrollment in your scheme?

6.2 How are eligible members identified?

6.3 What is the unit of enrollment: individual or family?

6.4 What is the process of enrolling members?

6.5 How is member counting done? Is it on basis of individual versus families; policyholder versus dependent, cumulative versus active status? Any other way?

Awareness generation and marketing

6.6 How does the scheme create awareness and attract members? Please share the strategies.

6.7 How are members informed about the product offering?

6.8 Has the awareness generation led to increased participation? Do you have any data to share on this?

6.9 Where are there gaps in awareness and how is the scheme addressing these?

6.10 What are the objectives of marketing and communication in your health insurance scheme?

6.11 What is the marketing and communication strategy?

6.12 Which entities do the marketing and communication for your mutual?

6.13 What are the standards for educating beneficiaries on health insurance?

7. Product Design and Features

Product design

7.1 Is your product/benefit package cashless or based on a reimbursement model?

If cashless product:

7.2 How is this cashless product designed?

7.3 How are providers empaneled?

7.4 How are providers paid for services delivered?

7.5 What is the mechanism for checking the quality of services?

7.6 What mechanisms are in place to prevent fraud?

If reimbursement product:

7.7 How is this reimbursement product designed?

7.8 How do you make sure that providers charge appropriately?

7.9 What is the mechanism of checking the quality of services?

7.10 What mechanisms are in place to settle claims?

7.11 What mechanisms are in place to prevent fraud?

Others:

7.12 Do you have one or more benefit plans? Or differential benefit plans (liberal plans and restricted plans) for different members depending on their category of membership? (For example, some insurers have a low, medium, or high product to serve different population segments.)

7.13 (If yes to above) What is the difference in enrollment and performance of the various plans?

7.14 In catering to multiple exceptions of the members, how do you minimize errors and costs?

7.15 What are the product limits and exclusions, if any? Are there any waiting periods?

7.16 Describe any major changes in the benefits package since inception. If there were any, what was the basis for deciding on those changes?

7.17 What changes are anticipated? When and why?

7.18 What happens when a member receives or opts to obtain care out of network?

7.19 How is the progress of the health insurance program monitored and measured?

8. Product Features (Including Health Care Ecosystem Created by Mutual)

8.1 What are the additional services you offer within the premium amount in your benefits package, for example, primary health care facilities or prevention activities?

8.2 Are health care camps organized for health care awareness generation? If yes, can you elaborate on the topics, frequency, locations, and target groups?

8.3 Does the mutual scheme own and operate outpatient facilities for primary health care?

8.4 Can you elaborate on the different ways you provide primary health care facilities?

8.5 If yes to the above, who provides outpatient services? What are the criteria used to select the provider?

8.6 What treatments are covered under primary health care?

8.7 What are the other services covered in your scheme, for example, drugs/medicines, loss of wages, or transportation?

8.8 Does your mutual also provide referral services?

9. Product Pricing and Premium Collection

9.1 What is the health insurance premium for members?

9.2 What method(s) do you use to determine the premium?

9.3 What is the pricing approach/structure (tiers) of the health insurance premium as applicable to individuals or families, with how many members, are parents included, are children included, any adult siblings, any age exclusions, and how do newborns become covered during the policy year?

9.4 What is the process you follow for revising benefits? What are the triggers, frequency, and level of community engagement for it?

9.5 What is ability and willingness of the target market to pay? How does the premium compare with other options, if available, such as RSBY?

9.6 Can you describe the household cash flow and how members deal with irregularity/seasonality while paying premiums?

9.7 How is the premium collected from beneficiaries (e.g., installment, in kind)?

9.8 Is there integration of the scheme with existing savings or credit facilities?

9.9 Do you have a grace period during which a person can renew a lapsed membership?

9.10 What is the process for reinstalling the policy? What happens if a claim is incurred when a policy has lapsed?

10. Use of Technology

10.1 Discuss use of technology (mobile app, management information systems, etc.) in your scheme. Do you use it for product designing, underwriting, distribution, and/ or in managing claims?

10.2 What standard solutions have been bought and used (not custom developed in-house or by vendor)?

10.3 Have you partnered with any technology firm to upgrade your mutual's digital know-how, improve efficiency, and offer a better customer experience? Which company have you partnered with?

10.4 If you use a mobile app for your work, for what purpose is it used? Are beneficiaries able to use it?

10.5 What are the difficulties you experience in management information systems?

10.6 Is there any type of technology that you are looking at using but have not been able to use so far? What would it be used for? What are the hindrances to using it?

11. KPIs of the Mutual

11.1 What are the total number of members on a specified date?

11.2 What is the incurred expense ratio? (Data required: incurred expenses, earned premiums; Source: P&L account)

11.3 What is the incurred claim ratio? (Data required: incurred claims, earned premiums; Source: P&L account)

11.4 What is the net income ratio? (Data required: net income, earned premiums; Source: P&L account)

11.5 What is the renewal ratio? (Data required: number of renewals, number of potential renewals; Source: scheme records)

11.6 What is the coverage ratio? (Data required: number of active insured, target population; Source: scheme records. Often the number for the target population will be an estimate unless it is a defined group such as MFI or cooperative members)

11.7 What is the growth ratio? (Data required: number of insured (yearly) Source: scheme records)

11.8 What is the turnaround time for claim settlement?

11.9 What is the claims rejection ratio? (Data required: number of claims rejected, number of claims in the sample)

11.10 Has the mutual received any subsidy? If so, how much?

11.11 How do you measure the impact of the scheme? Is it in terms of financial protection, reduced OOP, health improvement, etc.?

12. Claims

12.1 Who manages claims processing? If it is outsourced, to whom?

12.2 What is the process for submitting claims and receiving payment? Describe member, provider, and scheme roles in this process.

12.3 How do you ensure the authenticity of the claims?

12.4 Does claim adjudication vary based on a maximum benefit for the household (e.g., family floater)?

12.5 Do you provide support to members in filling out claim forms and other administrative requirements?

12.6 Describe the provider payment mechanism for inpatient and outpatient care. What is the fee schedule? Case rates? Per diems?

12.7 What type of claims get rejected and how often?

12.8 Where is the scheme most vulnerable to fraud, and how does your organization manage it?

12.9 How are disputes on claims addressed? When and how are exceptions made?

12.10 Do any services require preauthorization? If yes, describe the process.

12.11 What is the members' perception about the scheme and the benefits of the scheme for them? (Cognitive social capital)

12.12 What is the reimbursement to the outpatient service provider (if you have any) and how was the amount decided upon?

12.13 How are the outpatient service providers paid for their services, and what cost sharing is borne by members?

KPIs for claims

12.14 Describe claim patterns in terms of frequency and cost. What are the top several reasons for claims (e.g., maternity)

12.15 What is the average cost (pay out) per claim?

12.16 What is the average claim per person per year? What is the average cost of claims per person per year?

12.17 How does the scheme measure savings based on negotiated rates versus actual billed charges?

13. Health Care Providers - Service and Quality

Health care providers' clinical quality

13.1 Do you employ full-time providers (doctors, nurses, etc.)?

13.2 What is the range of private providers you empanel to provide health care services (e.g., hospitals, primary health care centers, private practitioners, and others)?

13.3 How many service providers are in the network?

13.4 What are the eligibility criteria for empanelment? Are they reviewed from time to time?

13.5 Is there a check on features of the providers/networked hospitals and health facilities in terms of cleanliness of premises, availability of diagnostics and drugs, or availability of prescribed medicines?

13.6 How often is the quality check done?

13.7 What are the rules for dis-empaneling a provider? How often is this done, and for what reason?

13.8 How are grievances handled? How many and what type do you get?

13.9 How do you monitor clinical quality? Do you use clinical guidelines and if so, how?

Service quality and access

13.10 What is the average wait time for members to seek treatment in the outpatient and inpatient departments?

13.11 Are members informed about any health problems by the doctors? Is there a mechanism by which you determine that?

13.12 How do you ensure that behavior toward members by the nurses/other service providers is respectful?

13.13 How is the patient-provider interaction based on patients' feedback?

13.14 What is the average distance to a primary care provider? A hospital? Are there geographic gaps in the network and, if so, describe how they are managed.

14. Regulations and Enabling Environment

14.1 How is your mutual registered? As a trust, society, or under the Companies' Act? Why did you choose your approach over the other options available?

14.2 How are the regulations and legal framework interpreted and used? What changes would you advocate, and why? How does the scheme engage with regulators?

14.3 Do you think it is easy for mutuals to function and be recognized for their work without regulations to support them? Why so?

14.4 Do you think the regulatory environment in India is getting to be favorable toward mutuals?

14.5 Are there any accreditation agencies for mutuals in India that you are aware of?

15. Sustainability

15.1 What are the challenges to sustainability?

15.2 What is your mutual doing to address these challenges? For example, what interventions have been implemented to product, services, awareness generation, etc., to promote sustainability?

15.3 How, and under what circumstances, might your mutual partner with insurance companies or government insurance programs?

15.4 Do you see government-run schemes such as RSBY as a threat to mutuals or can they coexist and facilitate each other's work? If yes, in what way?

ANNEX D: PRIVATE VOLUNTARY HEALTH INSURANCE IN INDIA

Since the advent of the new economic policy in 1991 and subsequent privatization of the insurance sector, India has experienced significant growth in insurance. Health insurance for long had remained an insignificant product component in the portfolio of public sector insurance companies. Recently, health insurance was recognized as a separate category of insurance, which previously was grouped as part of the non-life general insurance category. Today, there are five stand-alone private health insurance companies and along with 22 other public and private general insurance companies, they offer health insurance products in India (IRDA, 2016).

The total number of persons covered by the commercial insurance sector insurance in fiscal 2015-16[3] was 447 million, of which government-sponsored health insurance covered 361 million (76 percent) and 86 million persons bought insurance from commercial insurance companies. The coverage data above suggest that private voluntary individual and group insurance cover about 6 percent of India's population and government-sponsored insurance, including RSBY, covers about 18 percent. The gross premium underwritten in fiscal 2015-16 was Rs 24,448 crores (about $3.65 billion).

The market share of public sector non-life insurance companies is 64 percent, of private sector non-life insurance companies 22 percent, and of stand-alone private sector health insurance companies 14 percent. The market share of stand-alone health insurance companies is increasing, rising in the last three years from 11 percent to 14 percent (IRDA, 2016). The total health insurance business consists of the following segments:

- Government-sponsored health insurance accounting for 12 percent of gross premiums
- Private voluntary health insurance accounting for 88 percent of gross premiums
    a. Group (44 percent and declining)
    b. Individual (44 percent and increasing)

The private voluntary segment has registered a compound annual growth rate of 25 percent in the past 10 years.

Coverage by private voluntary insurance is likely to go up to 18 percent in next five to seven years (at current growth assumptions), and RSBY is likely to cover 30 percent. In other words, nearly half the population is expected to be covered.

[3] India's fiscal year is from 1 April through 31 March.

ANNEX E: MICRO-INSURANCE REGULATION OF 2015

The IRDA of India has created a special category of insurance policies, MI policies, to promote insurance coverage among economically vulnerable sections of society. The IRDA Micro-insurance Regulations were first issued in 2005. Revisions of March 13, 2015, supersede the regulations of 2005.

The new regulation makes a number of important amendments regarding:

- Guidance on product development
- Adjusting risk coverage levels
- Permitting more entities to distribute MI products
- Training of MI agents and their personnel

It also introduced a change in the existing compliance norms for insurance companies that had been established under the Rural and Social Sector Obligations (2002). Of particular relevance is the introduction of a new product category called "micro-variable life," a hybrid product category that offers the customer the benefit of systematic contribution with term insurance coverage. This product has a lock-in period of five years during which policy surrenders are not allowed, but partial withdrawals may be permitted.

The description of general MI products remains largely the same and includes (1) health insurance contracts and (2) any contracts covering belongings such as a hut, livestock, tools, instruments, or any personal accident contract. Products can be on an individual or group basis. Groups should have at least five persons.

The description of a life MI product also remains the same and includes a term insurance contract with or without a return of premium, any endowment insurance contract, or any health insurance contract. It can be with or without an accident benefit rider and on an individual or group basis.

The regulations (old and revised) allow insurers to offer composite coverage or package products that include life and general insurance coverage together.

The IRDA regulations make no mention of health mutuals and their potential role in the insurance sector. Even in the 2005 regulations, the only mention was of mutual aid cooperatives as MFIs.

Table E.1 compares the regulations of 2005 and the 2015 revision and shows the key areas of change:

Table E.1: Comparative Profile of Micro-insurance Regulations, 2005 and 2015

Component	Regulations of 2005	Regulations of 2015
Distribution	• NGOs • SHGs • MFIs	• NGOs • SHGs • MFIs • RBI-regulated non-banking financial companies • District Cooperative Banks • Regional Rural Banks • Urban Cooperative Banks • Primary Agricultural Cooperative Societies registered under the Cooperative Societies Act • Business Correspondents who have been appointed in accordance with the RBI Financial Inclusion Guidelines
Training	• No mandatory training	• Mandatory training period of 25 hours for individuals employed as MI agents ("agents and their specified persons") • Individuals selling non-life products to micro and small enterprises now need to undergo an additional 25 hours of training • Every MI agent or sales person needs to undergo refresher training for half of the specified mandatory training time at the end of three years
Risk coverage levels	• Ranged from INR 5,000 (approx. US$78) to INR 50,000 (approx. US$780) depending on the type of product	• For life INR 200,000 (approx. US$3,100), • For non-life INR 100,000 (approx. US$1,560) • For group health INR 250,000 (approx. US$3,900). • Aim is to enable insurers to target consumers across the lower middle-income segment, which remains largely uninsured because of the unattractive (low) coverage limits and poor access
Appointment of MI agent		• Deed of agreement shall specify the terms and conditions of such appointment, including the duties and responsibilities of both the MI agent and the insurer • An MI agent may work with one life insurance company and one general insurance company. In addition, an agent may work with the Agriculture Insurance Company of India Ltd and with any one of the health insurance companies registered with the Authority
Tasks an MI agent can perform		• Collection of proposal forms • Collection of health status self-declaration forms • Collection and remittance of premiums and issuing acknowledgements of collection of premiums • Distribution of policy documents • Maintenance of registers of all those insured and their dependents covered under the MI scheme, together with details of name, sex, age, address, nominees, and thumb impression/ signature of the policyholder

Component	Regulations of 2005	Regulations of 2015
		• Assistance in the settlement of claims • Ensuring nomination to be made by the insured • Any policy administration service
Underwriting		• No insurer shall authorize any MI agent or any other outsider to underwrite any insurance proposal for the purpose of granting insurance coverage
Handling grievances		• It is the responsibility of the insurer to handle and dispose of complaints against an MI agent promptly • Every insurer shall send a quarterly report to the Authority regarding the handling of complaints/ grievances, if any, against MI agents
Obligations to rural and social sectors		• All MI policies may be counted for the purposes of fulfilment of social obligations by an insurer pursuant to the provisions of the Act as amended from time to time and the regulations made there under • Where an MI policy is issued in a rural area and falls under the definition of social sector, such a policy may be counted under both rural and social obligations • The new regulation no longer recognizes policies sourced as part of social security schemes as MI and prohibits insurance companies from including them as part of their reporting on their rural and social sector mandatory targets
MI agent commissions		• For life insurance business: • Single premium policies: 10 percent of the single premium • Non-single premium policies: 20 percent of the premium for all the years of the premium paying term • For general insurance business: 15 percent of the premium. • Where the agreement between the MI agent and insurer is terminated for any reason, no future commission remuneration shall be payable • For group insurance products, the insurer may decide the commission subject to the overall limit as specified in sub-regulation.

Sources: *https://a2ii.org/en/india-adopts-new-irda-microinsurance-regulation*
CUTS C-CIER. Regulation of Micro-finance Institutions in India, Briefing paper: 2/2013

ANNEX F: GENESIS AND DYNAMICS OF MUTUALS IN AFRICA AND EUROPE

While mutual health organizations exist in many parts of the world today, they are most prominent in Europe and indeed have a long history there. More recently, they have gained popularity in Africa. However, the political, social, economic, and technical milieu in which the mutual movement began on both continents is different and presents an interesting case for analysis.

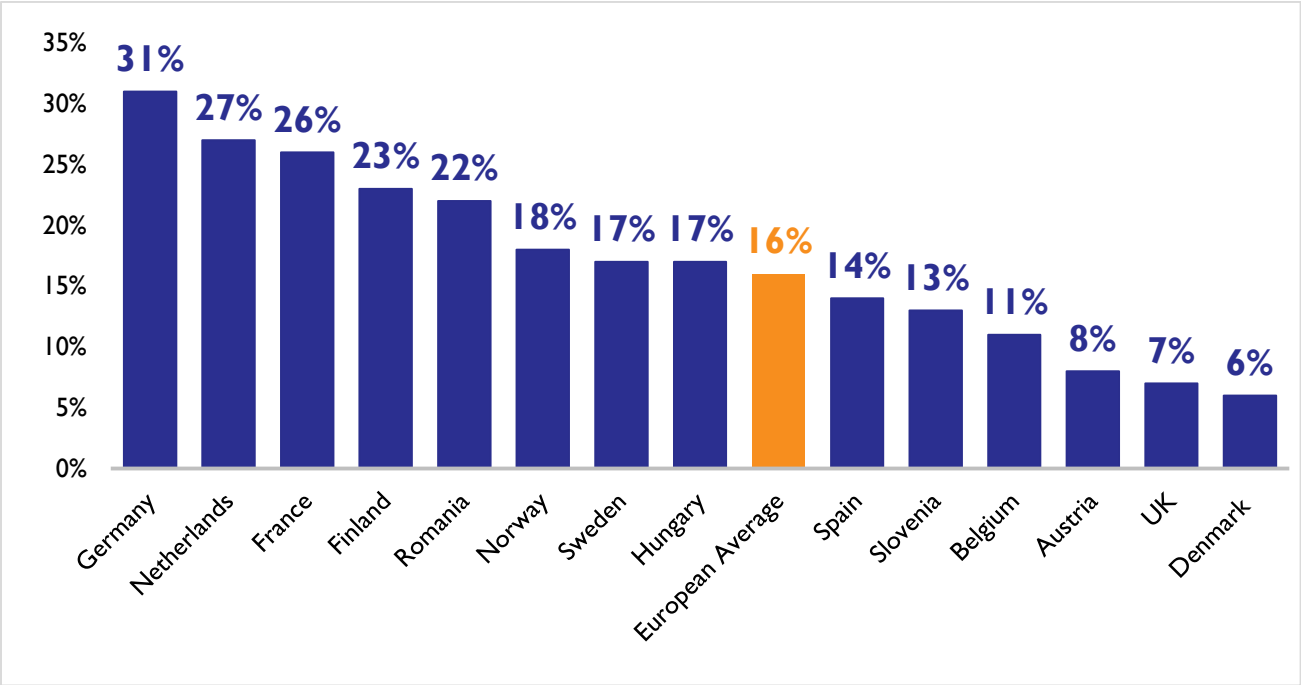
Europe: The first mutuals were established in the first half of the 19th century, early in the Industrial Revolution, and at the initiative of workers or employers willing to improve the living conditions of the workforce. They were called "*sociétés de secours mutuels*" in Belgium and France, and "friendly societies" in the United Kingdom. The main risks covered were loss of income in case of death, accident, chronic disease, or unemployment. Initially, the modest size of contributions, the small scale of most associations, and the lack of management expertise did not allow for economies of scale and jeopardized effective social protection (Swaan, 1988). Although working class and philanthropic movements rather than a public authority created these mutuals, they became effective and sustainable only after state intervention.

This intervention of the welfare state varied from one country to another. For example, in the United Kingdom, the state intervened directly and made the existence of mutuals superfluous. In countries such as Belgium, the mutuals remained and were gradually integrated into the national social health insurance system. In Germany, Bismarck introduced the first state-run social security system.

Today, the European Union has diverse legal forms for mutuals, but all share key characteristics such as operating democratically, being private legal entities and groupings of similar persons, adhering to principles of solidarity, and using profits for the benefit of their members. Mutuals in Europe account for 16 percent of the total European insurance market (21 percent non-life and 13 percent life), collect around 180 billion euros in premiums, manage around 1,160 billion euros in assets, employ around 200,000 people, and provide services to about 230 million people (Broek et al., 2012).

Figure F.1 shows the market share of mutual-type organizations in Europe in 2010.

Figure F.1: Market Share of Mutual-type Organizations in Insurance in 2010



Africa: Africa has a different socio-economic scenario from Europe. Most countries are either underdeveloped or developing and thus, the dynamics of mutual health organizations in Africa has features that distinguish it clearly from the situation in Europe at the end of the 19th century.

The concept of health insurance is not new to Africa. Bismarckian social health insurance systems were introduced in most states post-independence, but indicated colonial influence (Ron, Abel-Smith, and Tamburi, 1990). Despite various measures, access to health care remains more the privilege of employees of the public and private sectors than those who are poor, who live in rural areas, or who work in the informal sector. The latter three groups, who actually account for about 90 percent of the workforce in Africa, have hardly any health insurance facilities and thus find themselves in a vulnerable situation. That is a product of their difficult working conditions, lack of a long-term view, and poor access to health care (ILO, 2017). According to estimates of the World Health Organization (Van Lerberghe, 2008), half of the population of sub-Saharan Africa lives on less than US$1.25 per day, so that they have hardly enough money to survive, let alone for transport to hospital or treatment. If sick people are not treated because they can't afford it, their health deteriorates, and poor health in turn leads to even greater poverty. Each year, this vicious cycle leads more than 100 million people to become more impoverished, as a direct result of the cost burden of healthcare services.

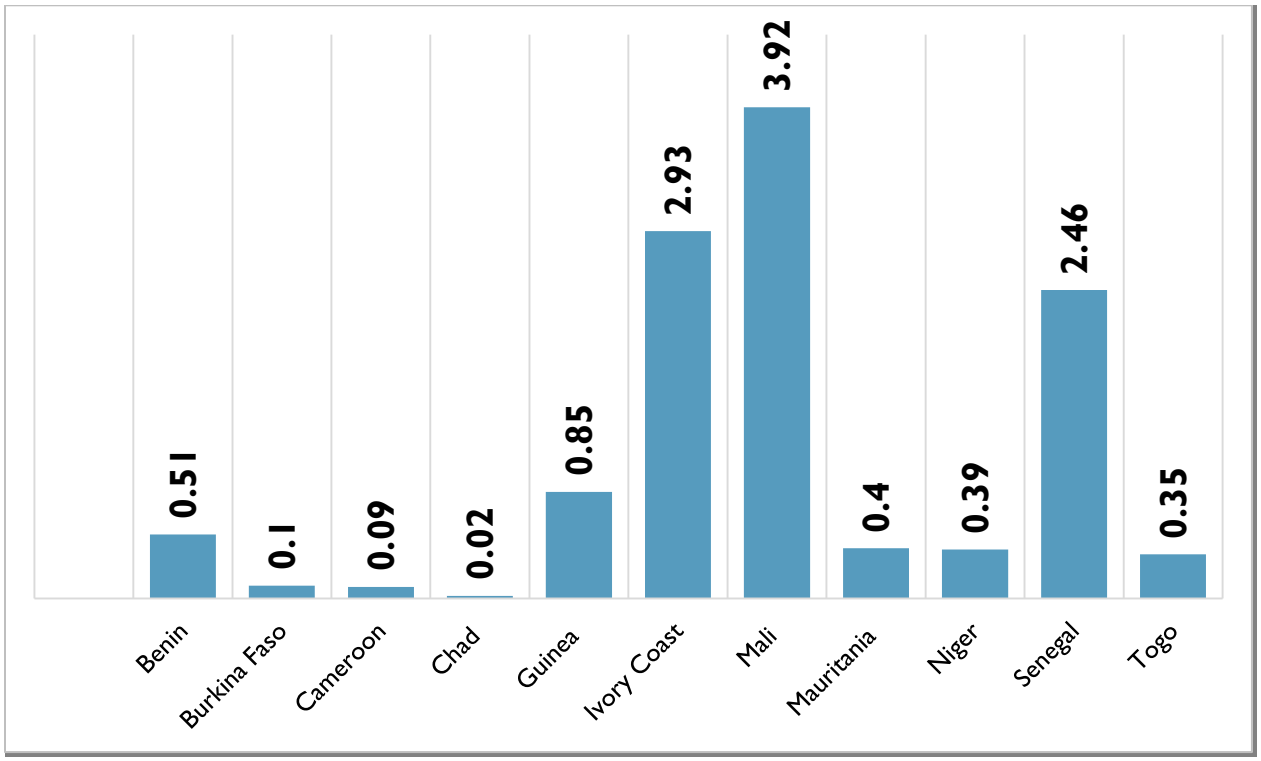
Micro-health insurance systems provide an interesting alternative for addressing the problem of the financing of health care, especially for the vulnerable groups discussed. A health mutual society is one of the MI systems that seems an appropriate model for Africa. It arises from principles of solidarity and mutual assistance. It appears to offer an alternative to poor women and their families who cannot afford health services and it is based on the idea of decentralization and subsidiarity (Develtere and Fonteneau, 2002).

However, unlike in Europe, the institutions that promote the concept of mutuals in Africa and offer technical support for their development often are outsiders to African society. The mutual health organization dynamic is thus to a large extent exogenous and possible links with endogenous mutual aid systems have hardly been studied (Criel et al., 1998). The range of international meetings organized in 1998 on the above in Africa indicates the interest of development agencies, non-African research institutions, and European mutual health organizations (mainly Belgian and French). Furthermore, the development of mutual health follows the current trend of increasing importance of the non-government sector in financing and provision of health care services.

Finally, in terms of the impact of mutual health organizations in Africa, Waelkens, Soors, and Criel (2005) found indications that CBHI improves financial access to health services and is in increasing demand due to increasing community acceptance. However, the authors also noted that mutual health organizations have limited financial capacity to cover expensive health care episodes.

A recent study conducted by International Labor Organization in collaboration with other international cooperation agencies has confirmed the phenomenon of the emergence of mutual societies in West and Central Africa in the last 10-15 years (ILO, 2017). A 2009 study, by UNICEF and the Overseas Development Institute, estimated that the number of mutual health organizations in that region grew from 76 in 1997 to more than 800 in 2004, and had more than 2 million members. However, although the schemes exist in all West and Central African countries and in most other parts of sub-Saharan Africa, few have a subscription of even 5 percent of the population. As Figure F.2 shows, the West Africa countries of Ivory Coast and Mali have attained the highest subscription rates of 2.93 percent and 3.92 percent, respectively (UNICEF/ODI, 2009). Mutual health organizations are typically found among women's groups, decentralized financing structures, socio-professional federations, and village groupings.

Figure F.2: Subscription Rates in West Africa



Source: UNICEF/ODI 2009.

As in India, these systems are generally small or medium-sized in relation to the membership in Africa and have limitations of (a) low subscription rates, (b) insufficient financial capacity, and (c) organizational and managerial problems/lack of technical competence. However, the success of mutual health organizations in Ghana, Tanzania, and Cameroon (Wietler, 2010) due to government political will shows that they have a great potential for improving access to health care, contributing to effective health care, and extending social protection to the vulnerable groups of the population. Rwanda is yet another interesting example. There is a formal recognition of the decisive role of mutual health organizations across the country, on the basis of two principles: (a) voluntary membership and (b) payment of premiums based on economic status. As a result, 91 percent of the population was insured through an mutual health organizations in 2010.

While the mutual health organizations are an important component of a health insurance system, they take the place of the state or national government. They can, however, benefit from state and external donor support for diverse needs and can even complement the work of the state, especially on the delivery side.

ANNEX G: MCCO CATEGORIES

Different countries recognize different forms of MCCOs (International Association of Insurance Supervisors, 2016). For example, in the United Kingdom, there are friendly societies, building societies, and industrial and provident societies. France has *sociétés d'assurance mutuelle* and *mutuelles*. India has four types of MCCOs, as discussed in Section 3: NGOs, SHGs, MFIs, and Cooperatives. Key differences between them are described in Table G.1.

Table G.1: Forms of MCCOs in India

MCCO	DESCRIPTION
Non-government organizaton	These non-profit organizations involve committed people and are registered as a society under any law. They are required to have worked with marginalized communities for at least for three years, have a proven record, and clearly stated aims and objectives. Transparency and accountability must be outlined in their memorandum, rules, by-laws, and regulations. *(International Association of Insurance Supervisors, 2016)*
Self-help group	An SHG typically is an informal group of 10-20 micro-entrepreneurs of a homogeneous social and economic background, voluntarily coming together to regularly save small sums of money, agreeing to contribute to a common fund, and agreeing to meet their emergency needs on a joint basis. They pool their resources to become financially stable, to borrow from the money collected, and with the objective to promote employment generating activities. They work together to ensure proper use of credit and timely repayment. SHGs may be registered or unregistered and they generally have broad anti-poverty agendas. They work on issues such as women's empowerment, developing leadership abilities among poor people, increasing school enrollment, and improving nutrition and the use of birth control. *(Reserve Bank of India. 2008. http://www.rbi.org.in/Scripts/FAQView.aspx?Id=7)*
Micro-finance institution	An MFI is any institution, entity, or association registered under any law for the registration of societies or cooperative societies for sanctioning loans or other financial services to its members, who are mostly from the poor strata of the population (except for the extremely poor). *(Microfinance Info. http://www.microfinanceinfo.com/micro-financial-institutions/)*
Cooperative	A cooperative is an autonomous association of persons (such as employees, residents, or customers) united voluntarily to meet their common economic, social, and cultural needs and aspirations through a jointly owned and democratically controlled enterprise. Cooperatives can provide any product or service. They differ from other businesses in that they use profits for purposes that are directed by the board and membership. Cooperatives exist in every sector of the economy and can touch every aspect of life There are workers' cooperatives, housing cooperatives, and insurance cooperatives. All cooperatives share the key guiding principles of: (1) voluntary and open membership, (2) democratic member control, (3) member economic participation, (4) autonomy and independence, (5) education, training, and information, (6) cooperation among cooperatives, and (7) concern for community. *(CMC. 2017. www.canada.coop/en/co-operatives-and-mutuals/what-co-op-what-mutual)*

ANNEX H: MCCO GOVERNANCE

Governance has been defined as the structures and processes to ensure accountability, transparency, responsiveness, rule of law, stability, equity and inclusiveness, empowerment, and broad-based participation (UNESCO, 2017). It usually also includes the relationships among the many stakeholders involved and the overall goals. Governance is often confused with management, but they are different; management comprises the planning, implementation, and monitoring functions used to achieve pre-defined results. MCCOs, like other enterprises, require capital investment, leadership, and management skills. However, their governance systems likely differ from those of other enterprises.

The International Co-operative Alliance (2015) has established seven principles and values that characterize cooperatives and mutuals and need to form the basis of their governance system. They are:

- Voluntary and open membership
- Democratic member control (and hence participatory decision making)
- Member economic participation
- Autonomy and independence
- Education, training, and information
- Cooperation among cooperatives
- Concern for community

At the international summit of cooperatives held in Quebec in 2012, most leaders of successful cooperatives and mutuals reported that management commitment and a robust governance structure were key to the success of their MCCOs. Key elements of a robust governance system include (Ernst & Young, 2012):

- Having a structure that facilitates member proximity and promotes responsive management
- Having a structure that gives priority to member needs. This might include, for example, an election or nomination committee that oversees the process of electing board members to ensure that the cooperative remains fair and democratic and has distribution channels adapted to member needs
- Being constantly informed of changing member needs and values and effective change management. For this, board members and community representatives can conduct regular meetings and focus group discussions to obtain information on members' needs
- Recognizing the value of virtual tools and emerging technology to engage with their members
- Ensuring transparency and trust, which are crucial
- Sharing and clarifying values of the MCCO to guide decision making and adopting a code of ethics
- Establishing clear conflict policies
- Training board members and managers on their roles and responsibilities
- Adapting quickly to evolving market trends
- Having a dashboard to monitor the key performance indicators of the MCCO.

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