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Microinsurance:

A Case Study Of An Example Of The Provider Model Of Microinsurance Provision

Gret Cambodia

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INTRODUCTION:

At one time or another in their lives, most people experience financial stresses that are potentially disastrous. This is especially true for the poor in developing countries. Much microfinance activity, including that which incorporates savings programs, has been done in an effort to relieve some of these stresses and help people to secure, and even improve, the financial status of their families. As a result, many poor people in developing countries have experienced improved household incomes. They also see the benefits of saving money, as well as maintaining a healthy credit relationship, to protect against future crises.

It has become clear that savings, though critical, address only relatively simple life cycle events and minor emergencies. The issues of health care financing, deaths, and property loss, for example, often require a greater level of support so that the involved family does not slide back down the slippery slope of poverty.

For this reason, there has been much discussion about the provision of insurance products to the poor in order to address the needs arising from such events. Indeed, several organizations have created programs to provide insurance products, utilizing any of four general models of insurance provision. These models include:

1. The Partner-Agent Model
2. The Full-service Model
3. The Mutual Model
4. The Provider Model

This series of case studies is designed to review some of the products of the more prominent organizations offering insurance products to the poor and to review their product development and implementation of these models.

The GRET case study is a partial example of the Provider Model of insurance provision since GRET is a mixed provider/full service insurer.[1]

Objectives: Although GRET Cambodia presents a mixed provider/full service example, this case study attempts to review its activities primarily within its role as a health care financing provider. Primary in-home care is offered by GRET as well as insurance coverage for certain secondary and tertiary treatments. The case study aims to provide an understanding of the mechanisms and practicalities of the Provider model, as well as an indication of the level of satisfaction of their market. Benefits and problems are identified, thus aiding in the identification of further potential applications. Additionally, this paper reviews the process by which the product was developed, tested, and implemented to provide information on the process itself and to identify issues in the product cycle.

1 The author wishes to thank the management and staff of GRET Cambodia who were extremely helpful and open in discussing their operations and lessons learned. Most of the information reported in this paper derives from discussions with them as well as GRET clients, and internal and public documents, which they kindly shared with the author. The author is also indebted to Janet McCord for her invaluable editing assistance.

Methodology: The assessment of GRET was conducted through a field visit during the period 31 July – 4 August 2000. The consultant conducted interviews, document reviews, and field visits. Mr. Soh Kim conducted Participatory Rapid Appraisal (PRA) and focus group discussions with clients, former clients, and non-clients. Claims records, as well as accounting and other documentation where available, were examined. The PRA was conducted in order to gain an understanding of the perspective of the market.

A review of findings and suggestions was provided to management of GRET Cambodia and discussed during the visit.

I. CONTEXT:

I.A: Macroeconomic & Legal Environment

Table I.A.1: Cambodia Country Basics[2]
(1998 unless noted and US$ where relevant):

GDP (US$ Billions)	2.9
Population (millions)	11
Surface Area ('000 Km^2)	181
GDP/Capita (US$)	260
GDP Growth Rate (1997-8)	(0.1)
GDP per Capita Rank (of 206)	187
Population per Km^2	65
Inflation (1999 est.)	4.5%
Exchange Rate (per US$1)[3]	3,800
PPP GDP per Capita (1999 est.)	710
PPP GDP per Capita Rank (of 206 countries)	175
Infant Mortality (per 1000 live births) 1970/1998	161/102
Under Five Mortality (per thousand) 1970/1998	244/143
Maternal Mortality (per 100,000 live births)	N/A
Access to safe water (% of population) (1996)	13
Health Expenditure as % of GDP (public/private/total)	0.6/6.3/6.9

I.B: Institutional Summary

In this case, the only relevant institution is GRET Cambodia (hereinafter GRET), which serves as both insurer and provider. Details of the institutional structure are noted below in Table I.B.1.

Table I.B 1: Institutional Structure

	GRET
Corporate Type:	NGO
Legal Structure	NGO
Core Products	Primary health care and insurer for secondary health care
Start of operations	1998
Number of Clients	405
Number of staff	5

A timeline of significant events in the creation and implementation of the GRET Cambodia project is presented in the table below.

[2] Data from 2000 World Development Indicators, World Bank, Washington, D.C. 2000. pp. 12, 16 and 92; and CIA – The World Factbook 2000 – Cambodia, http://www.odci.gov/cia/publications/factbook/geos/cb.html#top
[3] This exchange rate will be used in all calculations of current figures in this paper.

Table I.B.2: GRET Timeline

Date:	Event:
1991	GRET starts EMT (a solidarity group based MFI) in Cambodia
1996	EMT microcredit impact study identifies medical expenses a key destabilization factor in household budgets
1998	After a brief test within EMT, management decided insurance provision was too much of a distraction from their goal of rapid geographical expansion.
	GRET implemented an autonomous health insurance program
May 1999	The first premium intake for the formal test was conducted with premiums from 529 insured in one commune.
Sept 1999	The second premium intake for the formal test was conducted with premiums from 182 insured in a second commune.
May 2000	The second premium intake from the first test group was conducted with premiums from 223 insured.

I.C: Product Description

The components of the product are described in Table I.C.1.

Table I.C.1: Product Description Table:

	Health Insurance Program
Target Market (client type):	Rural poor
Target Market (geographic):	Two Cambodian provinces: Kandal and Takeo
Intended client benefits	✓ Improved health of rural families ✓ Improved financial stability
Product coverage: Primary Care - Children	✓ Respiratory tract infections ✓ Hemorrhaging fevers ✓ Typhoid fever ✓ Diarrhea ✓ Intestinal parasites ✓ Ailments of the eyes
Product coverage: Primary Care - Adults	✓ Respiratory tract infections ✓ Food poisoning ✓ Typhoid fever ✓ Asthenia (loss of physical strength) ✓ Intestinal parasites
Product coverage: Secondary Care	✓ Critical surgery related to the torso only (US$53) ✓ Natural Delivery (US$4) ✓ Delivery using forceps or suction (US$15) ✓ Delivery by caesarian section (US$48) ✓ Transport (for all secondary care except natural delivery conducted in home) (US$2.60)
Product coverage: Death	Any death (US$13) (except for children under 1 year)
Limitations	✓ Primary care must be provide by GRET doctor ✓ Coverage is limited to specific medical issues ✓ Secondary care is paid as a cash benefit regardless of cost of procedure. ✓ Medications must be purchased. GRET sells discounted drugs to insured ✓ Primary care from GRET available from 8H00 to 16H30 Monday through Friday and Saturday morning only.
Exclusions	None

	Health Insurance Program
Eligibility Requirements (and renewal terms):	✓ Resident of target commune. ✓ Whole family (living in same compound) must join
Pricing (premiums)	✓ US$1.58 per year per person
Pricing (co-payments – primary care only, per illness not per visit)	✓ Children=US$0.13 ✓ Adults=US$0.40
Other:	✓ Medications purchased by insured at discounted price ✓ Clients are issued identity passbooks which also serve as health records ✓ Medical check-ups are provided upon payment of premium to assess client's current condition and treat or advise. They are not used for exclusionary purposes.

II. MARKET RESEARCH

II.A: Market Definition/Segmentation

Ennatien Moulethan Tchonebatt (EMT), which means "rural lending" in Khmer, is a microfinance program begun by GRET in Cambodia in 1991. EMT showed a very strong focus on rapid growth with one solidarity loan product. As a result, by end of 2000 they reported over 75,000 clients.

In 1996, EMT had an impact study conducted on their clients which showed that a primary destabilizing factor for household budgets was illness.[4] The study demonstrated that although credit helped their clients move out of deep poverty, at any time, illness could strike and the resulting financial impact could quickly push them back into poverty. The issue was not only the initial outlay of cash to cover the treatment, but also the common practice of selling productive assets to acquire enough money to pay the health care bills. Thus, the clients were frequently unable to bounce back from the initial shock because their earning potential had been diminished. Clearly, health-financing issues caused problems with all aspects of household finances – including debt servicing.

In response, EMT and GRET decided to test a health care financing system – both wanted to create a mechanism that could help clients protect their income against future health care shocks.

II.B: Market Research Process

GRET and EMT conducted extensive discussions in villages with potential clients. These discussions focused on evaluating the basic understanding of the insurance concept and providing some concept education. Through these discussions, they assessed the potential demand for health insurance services. Once they perceived significant demand, they also discussed the many operational modalities in the villages in order to determine the best mechanism for getting health insurance coverage to the people.

In addition to discussions with client groups, EMT and GRET conducted extensive document studies of the variety of products, services, and experiences offered within the framework of an MFI. Savings products and emergency reserve funds were reviewed as potential solutions. Traditional insurance systems were considered as well, with an eye towards assessing their benefits and problems and to gain insight into what specific mechanisms were acceptable to the poor for health coverage. Finally, they surveyed a variety of family strategies for coping with health care financing crises. This research helped EMT and GRET to understand better how an insurance scheme might impact potential client livelihoods, as well as assess the real need for a new service.

[4] GRET. Experimenting with a micro-health insurance system in Cambodia: the EMT Example. A guest editorial at http://nt1.ids.ac.uk/cgap/html/products.htm. 2000.

II.C: Competitive Analysis

There was no competition for this product. When GRET and EMT first decided to address health care issues, there was very little provision of health insurance in Cambodia at all, and virtually none to the poor in the rural areas. The idea of health care financing was a new concept arising from insight into issues that no one had tried to address previously.

III. PRODUCT DESIGN

III.A: Prototype Development and Testing

The prototype was originally tested using two loan officers from EMT who added the health insurance system to their credit related duties. This did not work well. Because of EMT's overall strict focus on growth and quality, credit officers already had significant productivity and quality requirements in their normal operations. It was quickly seen that there was little incentive, or time, for them to promote and manage a health insurance scheme in addition to their credit activities. In an effort to provide incentive for them, a "new product management" bonus was established. However, the volume of work for these credit officers remained too significant to allow for any real progress on the new insurance product.

More significantly, EMT recognized that the effort and investment that it would take to develop the new business of insurance was too much of a distraction from the geographical expansion of their core product. Thus, EMT stopped the internal test and approached GRET to create an autonomous unit to provide insurance in coincident markets. From this decision evolved the GRET Health Insurance program. The product as originally designed as follows:

Table III.A.1: Elements of the Concept

Terms, conditions and coverage:	Reasons:
Villages selected to coincide with EMT	To provide health benefits to EMT clients
Individual premiums set at one price for adults and children	For ease of accounting and getting clients to understand the system
Combination of care through GRET doctors and public hospitals	Because of a lack of adequate health facilities, GRET saw no other option than to provide a doctor to offer primary care. Secondary care was to be provided by public hospitals.
Secondary care coverage as a cash payout	Recognizing the variable and non-receipted costs of care, plus the administrative burden of overseeing care costs and getting the money to the clients efficiently, GRET decided to provide a cash benefit rather than reimbursing the client for payments to the hospital.
In-home primary care provided	Because this was identified as the most likely to attract and efficiently service ill clients.
Annual premiums payable during a certain period	To minimize collection efforts
Significant training of potential clients prior to accepting premiums	To ensure that people understood the policy and the coverage.
Limit coverage to critical interventions	To reduce costs, control fraud, and maintain low premiums, primary coverage is for certain illnesses, and secondary coverage provides assistance only for surgery of the torso.

The primary objectives of GRET and its clients are outlined in Table III.A.2. It is clear that GRET's objectives were primarily client focused – they wished to help clients to better survive the shocks of health care financing. GRET recognizes the importance of tailoring the product for client satisfaction,

thus creating and maintaining demand, as the first step towards sustainability. Without an appropriate product, client satisfaction is unlikely, and there can be no sustainability. Where GRET sees much of the work is balancing the client demand for an appropriate product with pricing that clients can pay at levels that will satisfy the financial needs of the institution.

Table III.A.2: Primary Objectives of GRET and Clients

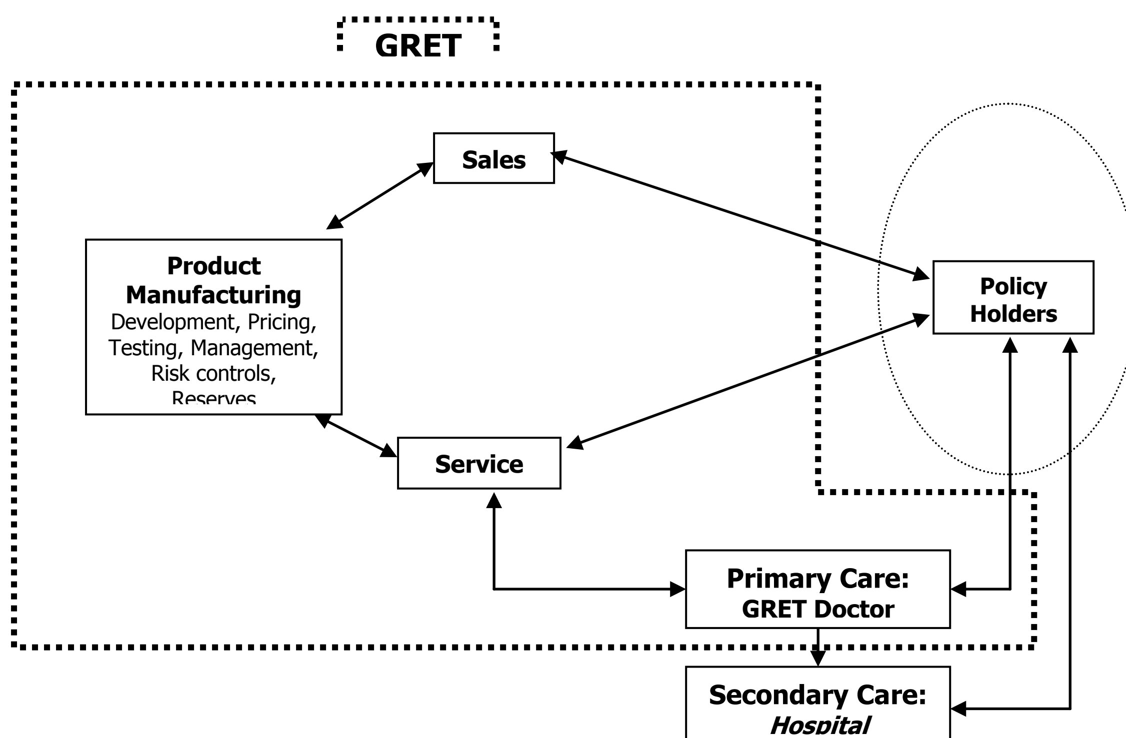
GRET	Insured Clients
Help people to avoid the risks of sudden loss of capital thus protecting household budgets	Improved health
Develop a system to cover the most serious health risks.	Minimize health cost shocks
Help rural families to cope more efficiently with the expenses related to illnesses and accidents	
Encourage access to quality health care.	
Develop a replicable system that results in improved rural health care and institutional, legal, and financial sustainability	

III.B: Delivery Channels and Partnerships

The following diagram indicates the sphere of responsibility for GRET in this program. All activities except secondary hospitalization are undertaken by GRET. This includes all activities related to both the insurance business (controls, management, reserves) as well as those of the insurance product (sales and marketing), plus the management of a primary care service. The actual treatment of clients is what puts GRET in the Provider model category. Their secondary care coverage is provided following the Full-Service model.

The arrows indicate interactions between different units. Note that there is no formal interaction between GRET and the hospitals. The GRET doctor and servicing staff visit insured patients in the hospital. The doctor visits the patient to confirm both quality of care and that the illness qualifies for coverage. The staff person visits to provide the cash benefit that will assist the patient to pay for the care.

Diagram III.B.1: GRET Health Insurance Responsibilities



III.C: Costing and Pricing

To determine premium and compensation levels, GRET undertook research in several areas. The steps they took included:

- ✓ An assessment of household contribution capacity within their intended market through discussions with families to determine average incomes
- ✓ An assessment of the penetration potential within the pilot zone
- ✓ The calculation of the total premiums expected based on contribution capacity and penetration expectations.
- ✓ Statistical risk evaluation to try to assess the likely risk to the covered medical issues and in relation to the client characteristics
- ✓ An assessment of what the compensation costs could be in order to balance the expected premiums

Initially, GRET charged a proportional premium according to family size. This proved cumbersome, so to simplify the process, it was decided that all policyholders would pay the same premium.

In calculating the price for the first cycle, GRET worked through their improvised costing model. Recognizing the deficiencies of this process, they engaged a consultant in June 1999 to assist them in working through an improved model. With this improved costing model, GRET management assessed the costs and set the premium for cycle two, which runs from June 2000 to May 2001.

At the time there was no other insurance program focused on GRET's market and there was very little utilization data for them on which to base their assumptions. They used demographic data and combined it with household surveys data about health risks, anecdotal data from hospitals and potential clients to further develop their assumptions. Based on these assumptions, operating cost projections, and planned coverage levels, GRET set its initial annual premium at 3,000R (US$0.80).

It was found necessary to significantly alter the delivery mechanism within the first few months of the program and this, coupled with better historical information gathered during the first year of operations, resulted in a dramatic reassessment of the premium for the second year.

IV. PILOT TESTING

GRET is still in the pilot test phase of this program. They started with an objective of getting health care coverage to the poor in the rural areas and have been testing different methods for accomplishing this. GRET suggests that they have not yet found the best answer to the problem of health care access in the rural areas, but will continue to test until they find a method that works.

The formal test by GRET began in April 1999 when they began meeting with clients to explain their insurance product. They followed a systematic marketing process and held two premium intakes during that year – in May and September – in two different communes respectively. The first intake yielded 711 insured in 7 villages, with an average penetration rate (population insured/total population in the village) of 27%.

During the insurance services design process, GRET quickly found that it was unrealistic to expect rural clients to go to clinics that were very far from their homes. Few and far-between clinics reflect a severe weakness in the healthcare system within Cambodia. GRET decided that in order to alleviate the problem of the unavailability of clinics for their clients, they would hire a physician and provide house-to-house care. The product was initially planned to cover health care at home only for children.

Within the first few months, adults did not understand why the physician refused to treat them when he was coming to treat their children. The physician's report to the team management encouraged GRET to extend health care at home for adults. This decision was made after the annual premiums

were collected so there was no opportunity for GRET to increase the premiums in order to cover the related additional costs (primarily the conversion of the physician's status from part-time to full-time). At the same time, it provided dramatically more convenient care at no additional cost to the adult clients, creating a perception that premiums covered this expanded service, and setting GRET up for a backlash when new premiums were announced for the next annual cycle.

Some of the issues that arose during the first year, and corrective actions instituted to address them, are outlined below:

Table IV.1: Product Issues and Corrective Actions

Issues:	Corrective Actions:
Difficult access to clinics for care	GRET hired a physician and began offering house-to-house care for insured members.
Diseases addressed were too limited	Expanded list to include additional critical illnesses yet continued the restriction to defined critical illnesses only. Specific coverage was added based on an extensive survey of client attitudes towards the program.
Cash benefit for transport (often provided prior to departure for the hospital) was seen as woefully low	Increased the benefit from US$0.80 to US$2.60
Client difficulty in gathering the whole premium once each year	Allowed the creation of solidarity groups to build savings for the annual premiums. There was limited use of this mechanism.
Ambiguity in coverage of children born during the premium year	Developed a system to provide coverage of newborns after birth.
Cost coverage was very weak and pricing was inadequate to lead to sustainability	Re-priced medications to cover direct plus management costs
	Increased consultation fee for children and adults from none to US$0.13 and from US$0.26 to US$0.40, respectively.
	Increased the annual premium from US$0.79 to US$1.58 per person
	Eliminated the premium per person reduction for households with over five members.

To adjust the price, GRET analyzed the data from the first cycle and the assumptions related to the enhanced coverage through their model. They set new premiums and co-payment amounts based on real expectations of covering these new costs. These financial adjustments resulted in a serious impact on clients at renewal time.

Other issues arose as well. During the first cycle in one commune, the government built, staffed, and equipped a health center. Government health centers now provide an incentive bonus to the clinic staff for production (they split the user fee income after a government-set quota is reached). This has generated antagonism on the part of the clinic doctor against GRET as a competitor for the patients he needs to help him make more money. GRET had tried several times to develop a relationship with this doctor, but these were constrained by the doctor's intense belief that GRET was taking his "rightful" patients, coupled with a misunderstanding on his part of how they could work together.

GRET persisted to build a working relationship with this doctor and the local clinic for three main reasons.

First, GRET's original intention had not been to become a competitor in health care provision. They wanted to develop a financing method for the poor in rural areas. The provision of care came about

only because of the lack of available health care in the rural areas. Thus, a relationship with a local clinic was consistent with GRET's original plan.

Second, the reaction by clients to the doubled premium had made GRET recognize the price elasticity of their clients and helped them recognize the need for more efficient operations to keep premium costs down. More discussion on the reasons for this is provided in the Results section.

Finally, GRET's doubling of the premium rate in order to cover costs and build a small reserve over time was based on several assumptions. One assumption was the "zone" population, critical to their projections. Some (assumed) factor of the population guided GRET's estimate of product uptake. New information revealed that their assumption of "zone" population was significantly overvalued. Using this more accurate data, and their current provision model, new projections showed that an even higher premium was required for GRET to reach a breakeven point. According to Pascale Le Roy, GRET's Chief of Project, considering the cost structure of the insurance model currently in test, it is clear that this model needs long-term subsidies for set up and continued operation.

After many visits with the local clinic, and subsequent to the author's field visit, GRET created a working group with health center staff, Ministry of Health provincial authorities, and UNICEF to discuss a possible partnership. The group has decided that creating a partnership allowing insured patients to be treated at the clinic, will benefit both the clinic and GRET, as well as the local residents. Because quality of care is critical, it was decided that GRET and UNICEF would first conduct an evaluation of the quality of care provided at the local health center. This exercise is expected to identify required improvements to medical practices at the clinic in order to assure quality care, and thus the foundation of a successful relationship. The evaluation is in process during the first quarter of 2001, and if all issues are addressed, a partnership arrangement should be implemented for the next annual insurance cycle.

Because GRET is on an annual cycle and they have again significantly altered their coverage, it is likely that the pilot test will continue for at least another one to two years as they work through the issues of health insurance provision in the rural areas.

V. ROLL OUT / IMPLEMENTATION:

This product remains in the testing phase and thus roll out has not yet begun. Part of the reason for the long testing phase is that the product is on a one-year cycle and only one commune has moved into its second cycle. Significant adjustments were implemented for the second cycle and the product remains in test.

VI. INSTITUTIONAL IMPACT:

EMT, GRET France's MFI partner in Cambodia, recognized the likely huge institutional impact such an insurance program could have on their growth focus. Unwilling to absorb this, GRET Cambodia was created as a new institution to address the insurance issues. This discussion focuses on the institutional issues addressed by GRET Cambodia.

VI.A: Human Resources

In starting this program, GRET was required to create an insurance company, a medical care "facility," and a pharmacy in order to respond to the needs of both the provider and full service insurer model. Systems and controls had to be developed and managed for each aspect of the business.

Because GRET is still in the testing phase and remains small (in terms of policyholders), it maintains a staff of six fulltime persons. These include:

- the GRET Chief of Project,

- an assistant manager,
- the medical doctor (technically a "medical assistant"),
- a village based insurance agent, and
- two facilitator-salespersons

GRET Cambodia also uses services of a doctor from Medecins Sans Frontieres (MSF) to provide guidance and limited oversight of their clinical and pharmacy operations at least once per month.

In creating the systems, GRET made several decisions to limit the scope of the different operations within the program. Insurance operations for secondary care are limited to certain medical procedures or events, and instead of reimbursing clients for secondary care fees, a set cash benefit is given (reducing the need for invoice verification). Insurance operations for primary care are limited to those provided by the doctor in the field, eliminating the need for physical medical facilities. Pharmacy operations are limited to those drugs sold by the doctor to insured clients.

Currently, the activities related to the three business areas are covered in the following manner:

Table VI.A.1: GRET Staff Responsibilities

	Insurance	**Primary Care**	**Pharmacy**
Chief of Project	General oversight, and policy matters	General oversight, and policy matters	General oversight, and policy matters
Assistant Manager	Staff management	Staff management	Staff management
Medical Assistant	Secondary care referral and review	Provider of primary care	Prescription, dispensing, and sales
Insurance Agent	Claims assessment, customer service, disbursement and collection agent	Claims assessment, customer service, collection agent, care gatekeeper	
Facilitators/Salespersons	Training and marketing		
Medical Advisor		Review and TA on clinical service	Review and TA on pharmacological issues

In addition to these areas of business, there is the business of running GRET as an institution. The COP, with the assistant manager, oversees finance and accounting, reporting, controls, and planning. The facilitators currently perform Field accounting and client tracking.

If GRET operations expand with their current array of business activities, each area of operations will become more demanding of specialized management.

VI.B: Operations and Systems

Systems were created to address the issues of GRET as a business entity as well as its three business areas. Procedures were developed and documented for all aspects of operations. Controls were also developed, documented, and implemented for the specific aspects of these operations (see Table VIII.1 – Managing Insurance Risks).

Adjustments have been made to accommodate alterations to the test including improved computer systems and altered operational procedures. GRET has been very strong in documenting procedures and policies.

VI.C: Feedback Mechanisms

Feedback is very strong in the GRET program and several mechanisms are utilized.

- The insurance agent not only conducts rounds in the villages each weekday, he also was chosen because he resides in one of the villages
- The doctor is in the villages each weekday
- Facilitators/Salespersons visit the villages frequently and offer trainings several times per year
- Assistant manager spends most of his time in the field with current and prospective clients
- GRET has also identified key persons in the village who act as focal points for claims facilitation as well as service feedback information.

The access that clients have to GRET staff and management provides many opportunities for both formal and informal feedback. Additionally, GRET occasionally conducts focus group meetings with clients and non-clients to better understand their perceptions of the program.

VI.D: Marketing

The marketing process begins in a new village or commune with discussions between GRET and local leaders. GRET explains their insurance and sets up a date for a grand meeting with the people in the area. GRET advertises the meeting house-to-house, and the local leaders promote the meeting through their communication channels. At the grand meeting, GRET explains the insurance product and how participants can benefit from it.

After this meeting, GRET management and staff meet with small groups of two to three families to explain the program again in greater detail. They use professional, laminated posters with all processes and policies diagramed in pictures for ease of understanding by the potential clients.

One to four weeks after these meetings, GRET accepts premium payments from interested families. This process is repeated at each annual cycle, and renewing customers must participate in at least the small group meetings. It is important to GRET that their clients understand the product.

Outside of the annual joining/renewal period, almost all staff have a broader marketing role within the target test communes on an ongoing basis.

VII. RESULTS

VII.A: Financial and Operating Results

GRET remains in the pilot test phase as their staff and managers work to develop a model that aids their clients and results in a sustainable institution. They have tracked their results and have made two rounds of significant methodological alterations to their model in searching for the elusive balance between level and quality of health care in the rural areas on the one hand, and the viability of the provider institution on the other. Table VII.A.1 below outlines GRET's original objectives in terms of the results they have seen so far.

Table VII.A.1: GRET Original Objectives and Results Observed

GRET: Original Objectives:	Results Observed:
Help people to avoid the risks of sudden loss of capital, thus protecting household budgets	Primary care insurance does assist people to gain care without a significant income shock. GRET insurance for secondary care, where the risk of household asset shock is much greater because of the sums involved, is not sufficient to keep families from significant asset loss in paying for secondary care services. GRET cash benefits cover between 13% and 55% of secondary care for their insured clients, with an average closer to 18%. Although GRET provides the cash benefit in a

GRET: Original Objectives:	Results Observed:
	timely manner, it still leaves the family with 45% to 87% of the total cost of secondary care.
Develop a system to cover the most serious health risks.	GRET has focused on the most serious of the medical issues that affect the rural poor.
Help rural families to cope more efficiently with the expenses related to illnesses and accidents	The efficiency provided by insurance is the ability to pay a premium in a controlled manner at a controlled time, and then if insured events occur (at an uncontrolled time) the financial shock is minimized or even eliminated. This does occur to a significant extent as noted above and below.
Encourage access to quality health care.	Clients report improvement in the quality of their health care through several mechanisms: • GRET primary care • GRET doctor's preventive advice which they say they follow • GRET doctor's recommendations on non-covered treatments • Increased "comfort" in dealing with doctors • Oversight by GRET of their secondary care (which is an important perceived benefit of this program)
Develop a replicable system that results in improved rural health care and institutional, legal, and financial sustainability	The search continues. GRET is actively monitoring its results and adjusting the model to improve its sustainability prospects but they are far from sustainable. Financial statements for the year 1 May 1999 through 30 April 2000, the first year of the formal test, show coverage of claims and operations by premiums and fees at 8.4% percent.

The inability to protect insured clients from the risk of secondary health care costs, even while covering only issues of the torso, dramatically limits the benefit of insurance to these rural clients. The results of an extensive survey conducted by GRET in 1998, in preparation for the formal test, showed that on average their potential clients were willing to pay 50% of the costs of their secondary medical procedures.[5] Yet, GRET's cash benefit for secondary care covers only between 13% and 55% of the actual costs of secondary care[6]. GRET clients must continue to sell their assets and accumulate large debts in order to cover such costs, even while insured. This minimal cash benefit impact is directly related to the health care context in Cambodia where hospitals do not apply clear prices for their services yielding highly variable costs. Much of this variability comes as a result of a healthcare workforce that is underpaid. This leaves them to extort unofficial payments from patients. GRET tried to negotiate a third party payment mechanism with a local hospital but the pricing offered by the hospital was unacceptably high since GRET wants to maintain a moderate premium. This situation presents a clear limitation that has driven GRET to set a fixed cash benefit to avoid cost escalation.

A major benefit of the insurance is the efficiency by which policyholders can get care in their own homes (given day and time of service constraints) by the GRET doctor. This doctor is loved by his patients, many of whom said they would not renew their insurance policies unless they knew that this doctor would continue to care for them. GRET's clients see his efforts at preventive care, as well as his oversight of secondary care, as a great benefit.

However, from an institutional perspective, GRET faces the dilemma of needing to provide more efficient care in order to keep premiums low. It is likely that they will need to move the health care provision to local clinics (where possible) to improve efficiencies. This will reduce one of the most

[5] From internal document, "Survey Results on Insured Members" December 1998.

significant perceived benefits by GRET clients and dramatically alter the nature of the institution. Already GRET is testing this in their largest test market.

GRET experienced significant dropouts between their first and second cycles, as noted in Table VII.A.2. Of the three villages GRET works with in Rolous, 69% of the families participating in Cycle One did not renew for Cycle Two. In one village, only one family remained with the program.

Possibly a more significant problem is the declining penetration rate within the villages. Not only does this reduce the size of the risk pool and the premium inflow (covering mostly fixed costs), but also it makes house-to-house service less efficient.

Table VII.A.2: Evolution of Membership - Rolous[7]

	All Families Cycle 1	Drop-outs after Cycle 1	New Families Cycle 2	All Families Cycle 2	Penetration Rate Cycle 1	Penetration Rate Cycle 2	Cycle 1 Drop-out rate
Village 1 (KT)	71	39	17	49	39%	27%	55%
Village 2 (Kan)	21	17	2	6	13%	4%	81%
Village 3 (PT)	27	26	-	1	29%	1%	96%
Total/Average	119	82	19	56	27%	13%	69%

Some of the reasons for high dropout include:

- The increase in the premium. Although clients were informed at least one month in advance, many reported that they were unable to pay the new amount. Other issues related to the increase include:
    - The requirement that all members of a family had to join for a family to be allowed to participate multiplied the premium increase by the number of family members.
    - The large nominal increase in the family premiums were difficult to acquire in a short time since even if people had reasonable mechanisms to save for premiums, this change would have still created great problems for families. Especially the poor need time and efficient mechanisms to save for premiums.
- The timing of the premium acceptance period did not fit with some clients' inflow cycles.
- Dissatisfaction with the limited coverage
- When the price doubled, clients perceived no additional benefit for the increased cost.

GRET is addressing some of these issues. Coverage is discussed with clients frequently but GRET must maintain the premium/coverage balance. They are allowing premium payments twice and in some cases three times per year. GRET has tried to get local families to form savings groups to assist in accumulating their premiums. This method has not proved successful because people report being skeptical about the security of their money.

GRET will need to calculate the next year's premium far in advance in order to improve the ability of the members to generate the necessary savings, especially if there are to be any additional premium increases. This re-emphasizes the need for conservative initial pricing, allowing for subsequent price reductions or at least minor increases in the future.

Client perspectives on the product:

Prior to membership with GRET, the ill used several strategies to deal with illness. Some would often simply wait it out if it were not seen as "serious." Others would self-medicate with drugs purchased from local pharmacies.

[7] GRET internal document, "SAM Membership – Rolous – Evolution Cycle 1/Cycle 2", dropout rates calculated by the author.

Those that sought formal treatment started with the local health centers and went on to hospitals if necessary. The costs were relatively high and people had to pay for consultations, procedures, medicines, tests, injection fees, food and transport costs, and even “fees” for “quick service.” Financing medical treatment was a serious problem for these people.

Table VII.A.3: Client Original Objectives and Results Observed

Clients: Original Objectives:	Results:
Improved health	Clients relate that they are in better health both because of the preventative and curative care they receive from the GRET doctor.
Minimize health cost shocks	Clients report being happy with the primary care, its minimal co-payments, and the efficiency of accessing health care from home. They also see the costs of medications sold by GRET as cheaper than those from drug shops or pharmacies. These minor shocks are mitigated by the insurance coverage. Though GRET does have a positive impact on secondary care through rapid disbursement of cash benefits, these amounts are not enough to “minimize” the expense shocks to their clients.

Several strategies were employed to finance health care. These include (in the order people report attempting to access them):

- Personal and family savings
- Borrowing from other relatives (no interest for a week but then 10-20% per month)
- Borrowing from a close friend (no interest for a week but then 10-20% per month)
- Borrowing from the wealthy of the commune (they lend free for 15 days)
- Borrowing from local moneylenders (reportedly at 20% interest per month)
- Borrow from a non-local lender (>20% interest per month)
- Pawn or sell household or business assets
- Sell land or residence

To pay off the debts, people must often still sell assets or land. This leaves them less able to generate household income, and more poor.

With GRET, the insured report receiving better, more efficient care from the GRET doctor who comes to their house and diagnoses their illnesses, and treats specific illnesses. This is clearly much appreciated by the insured who report that this method saves them money, is much more convenient, and provides them with greater confidence in their health care. One member reported:

> **"Before, I used to spend 20,000 to 100,000 riels [US$5.25 to 26.30] when I was sick for one week but now since I joined the scheme I spend very little in comparison to what I spent for the medication before and I can access the efficient medical service. On top of this I am advised by the doctor on costless ways to care for sickness"**

Another member from a different area noted her confidence in the doctor by relating that:

> **"During the busy time, especially rice transplanting season, I leave my children at home, and sometimes they get sick. I used to worry about them when I was away but now I know that the doctor will come to the house and take care of my children when they are sick".**

Clients and former clients reported great satisfaction with the GRET doctor. They were confident in his care and enjoyed the efficiency of being cared for at home. Although the doctor is restricted in his treatment by the GRET policy, people appreciate that he recommends drugs and treatments even when they are outside the scope of the policy. Many clients reported the benefits of the doctor's discussions with them on preventative measures that they should take, and report implementation in their homes of many of these suggestions. This is an important benefit of this service in that clients potentially remain healthy, and the costs to GRET are reduced.

PRA groups all reported dissatisfaction with the primary service on nights and weekends when GRET provides no primary coverage. During those periods, clients must use the local clinics for which they must pay (with no reimbursement from GRET).

Most clients accept the restriction on medications and consider the available medications as cheap and effective for their families. There were several complaints from clients who perceive that these generic medicines are not as effective as name brand medications.[8] Two clients reported that subsequent to receiving drugs from GRET they felt they still required more effective treatment and thus went for care at a clinic. This complaint about generic drugs is very common and is heard throughout the world. It is generally a result of drug company advertising, and private physicians who promote name brand drugs to improve their profit margin and who in some cases earn commissions or "gifts" from the drug companies.

Those participating in PRA discussions almost uniformly found the coverage too restrictive. The limited primary coverage addresses mostly medical issues of children (the initial intended beneficiaries of this program), and the restrictions on secondary care exclude many relatively common medical problems. This reflects the common balance that all insurers must address, that of premium versus coverage. GRET recognizes the need to cover its own costs and generate a reserve in a market where people are considered poor. Getting clients to cover the costs of as much care as possible given the financial constraints of the insurer is a difficult balance. It is GRET's objective to cover the critical illnesses and medical procedures that their clients face at a price those same clients can afford.

It is the insurer's job to maximize coverage and maintain efficient operations so that clients can pay for more coverage. Even with restricted coverage, GRET's operations are still inefficient since they offer in-home care to a limited clientele. The fixed costs in this insurance program are high partly because of the need to have a full time medical practitioner and an insurance agent in the same market area every day. The inefficient use of such professional staff drives up costs and drives away clients, requiring further premium increases. Thus, the insured in this program must weigh the benefits of in-home care (with its high costs) against the inconveniences of gaining care from a clinic (which has the potential for much more efficient operations and thus reduced premiums to the client). In a very real sense, in order to reduce premium costs, some of the inefficiencies must be borne by the client.

[8] In these areas it is considered necessary by many to receive an injection to get well. Although the GRET doctor provides injections when clinically necessary, some people perceive the lack of an injection as poor care. GRET staff are working to educated their clients but change in this area has been slow.

GRET is recognizing this issue and, subsequent to the author's field visit, they are discussing with the local clinic in one commune to evaluate the feasibility of a partnership to treat GRET's clients. This system would utilize an existing structure that is able to provide more comprehensive care (at least in terms of hours of coverage).

The issue of "mission drift" and retaining the poor is also an important consideration in the price-coverage balance. GRET wants to serve and retain the rural poor and thus must factor their ability to pay premiums into their price-coverage mix. In fact, GRET factored this issue into their pricing criteria. This is the main reason why GRET coverage is so restrictive. Currently they report the following wealth ranking of their clients in one commune. These rankings are based on household surveys utilizing several wealth proxies previously identified by village key persons. Please note these are *relative* rankings within the rural village context.

Table VII.4: Wealth Ranking of GRET Clients

Category:	% of Total
Very rich	5.4%
Rich	14.3%
Average	60.8%
Poor	17.8%
Very poor	1.7%

It is clear that in this relative context "very rich" is hardly rich and "average" represents a vulnerable group. The fact that GRET is not reaching the "very poor" is a reflection of the premium cost.

Several people in PRA groups who would be considered "very rich" or "rich" reported that their health is relatively better than that of the average and poor people, but they pay the premiums as a way of assisting their community.

The process of client referral to hospitals, review by GRET while a patient is hospitalized, and payment of the cash benefit while the patient is in the hospital, are all seen as important benefits of the insurance by clients.

Clients report (through data collected by GRET) that the cash benefit covers little of the total cost of hospital care. As mentioned, recent GRET data shows that the coverage rate for medical expenses (inclusive of at-home follow-up care costs) ranges from 13% to 55%. Total expenses to the clients (inclusive of medical expenses plus associated costs like food and transport) are covered between 11% and 23%. The average medical cost coverage (with clients using different facilities and calculating all covered procedures) for the year ending June 1999 was calculated at about 16%.

The result of these coverage rates is that, even though the cash benefit is provided in the hospital, clients still must fall back to their old financing mechanisms (depleting savings, borrowing, or pawning or selling assets) when serious illness strikes. The additional benefit they get with the insurance is often assistance at check-in with the hospital, medical care oversight while in the hospital, and GRET follow-up care when they return home.

Although in the PRA meetings several people expressed misunderstandings about the policy and its coverage, GRET provides several opportunities for people to learn about and clarify issues relating to the policy. Communications with clients in this program have been extensive and frequent. Part of the reason for this is that the insurance program is still in its test mode, GRET wants to know what clients think, and they want their clients to fully understand the product. Some of the ways GRET communicated with clients include:

- The insurance agent is in the village every day
- The doctor is available each day

- GRET holds mass meetings in the villages prior to the premium payment period
- GRET holds small group meetings with every client family prior to their payment of the annual premium
- GRET holds occasional special meetings in villages when a policy change is made or there is a particularly pervasive misunderstanding.

VII.B: Corporate Culture

The GRET corporate culture has been one of active research towards a product that can satisfy the critical health needs of their clients in the rural areas, while creating a sustainable institution. Balancing these issues has led to the significant alterations described above.

Management sees the necessity of ultimate sustainability as critical to the project in the long term. They offer that if at the end of the test the resulting product does not project into sustainability in the near term, the project will not continue. For GRET, a good product without sustainability is not sufficient reason to continue. That understood, GRET remains committed to developing a system of healthcare insurance for the rural areas, and will continue to adjust and re-adjust their program until they can find a combination that works for both the institution and the rural poor.

VII.C: Product Development Process

Being in an environment where insurance to the poor has been unheard of, and medical service utilization by the poor has been undocumented, GRET has followed an approach using cycles of study, implementation and adjustment in order to build up the knowledge that they need to develop a business that satisfies their objectives. This effort of learning through active testing has defined their development process.

VII.D: Plans for the Future

GRET offers that if the system they ultimately develop balances their client and institutional objectives, then they expect to create a new local institution that is organizationally, legally, and financially viable. GRET recognizes this as a long-term goal. If, and when, they conclude the test with a product they believe to be viable, they will still need to move through the expansion phase to test the system's ability to adapt to a wide diversity of environments and institutional stresses.

They suggest that final acceptance of the system will likely require several major activities including:

- Continual reassessment of the premium, balancing client demands for broader coverage with coverage of costs plus reserves. This will require efforts to:
  - Improve institutional efficiencies
  - Reassess their ability to provide in-home primary care
  - Dramatically increase the retention rate
- Developing relationships with medical partners such as clinics and hospitals to facilitate their insurer role and allow a reduction in their direct treatment. Partnerships with doctors' associations are also anticipated in order to assist in improving the general level of medical care in rural areas.
- Work with the Cambodian Ministry of Health in order to legalize their ultimate structure in a progressive manner.

VIII. Summary of Lessons Learned

- ✓ Where possible an insurer should utilize existing infrastructures (such as an existing health care system) to improve efficiencies and keep costs minimized in order to assist in maintaining premiums at a level that poor clients can manage. For example, where there are clinics of acceptable quality, an insurer might be more efficient having client health needs

serviced by the clinic, rather than developing their own clinic or health service provision. The costs of inefficiencies will have to be borne by either the clients, or taxpayers (in the form of donor aid). A responsible institution should work to minimize inefficiencies where possible.

- ✓ When starting a new insurance business in an area where there has been none before and where there is little data from which to make assumptions for projections, it is important to track the data aggressively so that you can make necessary adjustments rapidly.
- ✓ An annual insurance cycle with set entry points greatly facilitates the administrative activities of the insurer, but can act as a deterrent to potential clients who do not have the money at that time due to seasonal or other reasons, and because of the relatively large level of cash payment required by the insurer. This is a critical factor in determining how much a client can comfortably pay for insurance. When payment or savings mechanisms allow for frequent small payments this is much less painful to clients than requiring one relatively large payment. This alone will have a strong impact on client uptake and potentially on client retention.
- ✓ GRET's test of providing health insurance in rural areas shows that one may need several iterations of the methodology to make the product work for both the institution and its clients.
- ✓ The severe 100% increase in premiums for Year Two caused problems for clients and resulted in a very high dropout rate between Years One and Two. Although difficult in an environment where there is no quality health care data and where there are no models to follow, it is important to price conservatively to avoid the problem of dramatic increases in premium costs corresponding to limited or no improvements in the coverage.
- ✓ The input of a doctor, above and beyond direct provision of health care, is highly beneficial to clients and the institution in providing preventive care and health care oversight. This provides credibility to the insurer, improves client health, and likely saves money for the insurer.
- ✓ Significant alterations to the model should be made prior to the payment of premiums so that the institution can provide services as contracted, and more properly price the product. Alterations within a premium cycle make tracking the test much more difficult. It may be advisable to reduce the premium period during the test phase (and possibly in implementation as well, given the issues of this market) so that program adjustments can be made more rapidly without losing the integrity of the test. Like all insurers, GRET must be concerned about the many risks of the insurance business. Of particular importance are the risks of moral hazard, adverse selection, cost escalation, and fraud and abuse. Table VIII.1 provides a summary of the general and specific strategies used by GRET to address these risks.

Table VIII.1: Managing Insurance Risks: Strategies Used by GRET

Risk:	General Strategy[9]:	Specific Strategy:
Moral Hazard	Pre-selected providers	Primary care is provided only through the GRET doctor
	Claims limits	Secondary care is covered with a set cash benefit that is provided regardless of the actual cost of the care.
		Primary care is limited to that provided by the GRET doctor
	Co-Payments	Required for primary care (adults US$0.26 and children US$ 0.13 per illness, not per visit)
		Insured must pay medications though GRET offers them at a discounted price
	Coverage restrictions	Covered medical conditions are specifically defined by inclusion in the policy and are restricted to serious medical problems.
	Loss review	Exercise conducted monthly with annual premium adjustments

[9] General strategies are taken from Brown, Warren and Craig Churchill. Providing Insurance to Low Income Households. Part 1 – A Primer on Insurance Principles and Products. Microfinance Best Practices project, DAI, Bethesda, MD, 2000.

Risk:	General Strategy[9]:	Specific Strategy:
	Exclusions	Policy is very specific about exactly what will be covered
	Waiting periods	Must wait until annual joining period
		Physical provided after premium payment
		Because GRET only treats acute problems the need for a waiting period is minimized
	Proof of event	GRET doctor and/or insurance agent view the stitches/wound in case of surgery, baby in case of delivery, or body in case of death.
		GRET doctor must provide primary care
	Client identification	Passbooks required for care. These contain identification and the client health records.
	Pre-approval of treatment	Covered primary treatment under complete control of GRET doctor and insurance agent
		Secondary care is based on referral by GRET doctor
	Expense verification	Unnecessary as primary care provided directly by GRET and secondary care covered by set cash benefit
	Clinical treatment verification	GRET doctor meets with hospital doctor to verify proper treatment.
		GRET accesses doctor from MSF fortnightly to oversee treatment by GRET doctor
	Deductibles	No deductibles
	Initial exams	Provided after premium payment to assess health status and make proper recommendations for care.
	Use of preexisting groups	Clients accessed as family units within a village. Information asymmetries often addressed by groups are mitigated through relationships with village leaders and by working with neighbors
Adverse Selection	Membership from existing groups only	Not required
	Whole family membership required	Strictly enforced. Family defined as all those "regularly eating from the same pot"
	Required membership within groups	No specific uptake requirements within villages
	Defined risk pools	Premium is the same for all, though co-payment is different for adults and children.
		Aim to access all people in a village
	Waiting periods	Must wait until annual joining period
		Physical provided after premium payment
		Because GRET only treats acute problems the need for a waiting period is minimized
	Tying insurance to other products	GRET offers no other product
Cost escalation	Periodic cost evaluation	Evaluations conducted monthly with premium adjustments made at each group's annual renewal
	Preset pricing agreements with providers	GRET provides direct primary care
		Secondary care cash benefits are paid based on a set coverage amount per medical procedure and stated in the policy.
	Preset drugs list	GRET uses a preset list of generic drugs which it sells to clients at a discount

Risk:	General Strategy[9]:	Specific Strategy:
Fraud and Abuse	Co-payments	Required for primary care (adults US$0.26 and children US$ 0.13 per illness, not per visit)
	Computerized ID systems	Manual system utilizing an identification passbook which also holds the client's medical records.
	Coverage limits	GRET provides direct primary care of specific acute illnesses
		GRET provides a fixed cash benefit for specifically defined secondary care
	Financial Accountability:	Insurance agent transacts premium collection and cash benefits disbursements in the field and in cash. Staff other than the agent educate clients on what they should expect once premiums are paid. Clients are an integral part of the GRET controls over the agent.
		Limited oversight from GRET France
		Accounting reports prepared in a timely manner

Table VIII.2: GRET's Strengths, Weaknesses, Threats and Opportunities

Strengths of the program
Preventive health care education provided by the GRET doctor and used by the clients is helpful in improving client health and in minimizing the cost of care to the insurer.
Client communications – Very participatory and informative to the clients. Strong effort made to keep clients informed of changes. HOWEVER, people remain unclear about insurance and the scheme, they do not read the contract.
Strong Planning – Alterations to the coverage are closely scrutinized by the team and management for their impact on sustainability.
Rapid cash benefits distribution – Very few insurers are able to get hospitalization benefits to the client while they are still in the hospital.
The doctor (medical assistant) – Provides very significant value added even beyond the direct curative aspects of his work
Strong systems moving towards computerization (necessary for growth) – good detailed tracking and control systems which will require computerization that is already in process
Convenience for clients (location) – Having home health care is better than most people get anywhere!
Institutional focus on sustainability – It is clear that a requisite for continuation is sustainability
TA arrangements with MSF – positively impact the capacity building and some oversight of the clinical operations
WEAKNESSES of the program
The fixed annual entry point makes it difficult for people to join when they do not have the funds available at that time.
There is no savings mechanism to assist clients to save for the premiums. GRET is planning to alter the annual premiums to semi-annual and possibly three times per year.
Inability to provide primary care during nights and weekends is highly restrictive to clients.
Low expense coverage rates for hospitalization yielding a very limited impact on reducing the financial shock of medical care on clients.
Product coverage (array of primary and hospitalization coverage) – does not cover some significant health shocks to families
Inflexible enrollment/renewal period – Having a single month to enroll/renew helps to minimize operational costs but seriously limits client ability to participate, especially if the timing of their income flows is not considered.
Expensive cost structure – field operations are about 40% of premiums at break even (with 60% as cash payments). Better collaboration with the existing health care centres and hospitals could reduce the costs.
Convenience for clients (timing) – only available during weekdays
High drop-out rate (69% in Roluos Y1 to Y2) – due to price increase, problem of understand the pooling concept, and product issues

Lack of reinsurance or reserves, though have coverage from GRET France
THREATS to the program
Insurance law being developed – this must be watched carefully to ensure GRET's insurance activities remain legal
Operations / claims costs pushing price and reducing coverage – partly because of high operations costs
Client perceptions regarding the need for injectable medications is leading to a perception of GRET as not providing adequate care – A positive perception by the public of the GRET products is a key to growth. However, GRET cannot provide dangerous coverage. Education on this issue needs to continue.
Then incentive system provided to the clinic doctor where GRET now has some of its clients treated in one commune will have an incentive towards fraud and moral hazard. GRET will need to provide strong clinical and cost scrutiny over the invoices from this provider.
OPPORTUNITIES for the program
Possibly provide extended coverage on a fee basis to primary care clients since medical assistant is diagnosing the illnesses anyway.
Possible interest from Indochine Insurance – as an insurer or re-insurer. Possibly they could cover parts of the GRET policy.
Government's effort to improve the operations and quality of health centers – should provide potential partnering arrangements that could improve GRET field efficiency and provide more comprehensive care to GRET clients.
Potential partner in EMT – Once a successful model is developed and tested, more intense work with EMT clients could help GRET rapidly gain client volumes with greater efficiency. This type of relationship might require alterations to the model to take advantage of the efficiencies and such issues should be considered during the test.