Demystifying health insurance package design by Choosing Healthplans All Together (CHAT)

India
David Dror
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illiterate and innumerate people can participate and decide on the composition and price of their health insurance. The process creates transparency and introduces democratic choices as an integral part of designing health insurance – breaking the monopoly of insurance companies on this crucial aspect of health financing.

A short (5 minute) video about CHAT is available for viewing on www.microinsuranceacademy.org

The primary beneficiaries of CHAT are communities at the “bottom of the pyramid”, who are able to participate in making decisions on their priorities in health insurance, and Choose their Healthplans All Together.

By involving communities in benefit package design, health insurance becomes much more acceptable and accessible to poor communities, and the complex concept of health insurance becomes clearer and less threatening. For instance, more than 95% of the groups which have participated in CHAT in Rajasthan, Maharashtra and Karnataka expressed interest in buying the insurance package they designed. In addition, as health insurance penetration is increased, out of pocket spending (the least efficient form of health financing) is reduced, shifting towards insurance and other more efficient prepayment and pooling mechanisms.

In India, the insurance industry functions on the assumption that “insurance is sold, not bought”. Our experience disrupts this top-down approach, and allows poor communities to make their own choices about benefit package design. To the best of our knowledge, CHAT is the first and only such process in developing countries.

About You

Location

- Project Street Address
- Project City
- Project Province/State
- Project Postal/Zip Code
- Project Country

Your idea

Focus of activity

Service/process

Year the initiative began (yyyy)

2005

Positioning of your initiative on the mosaic diagram

Which of these barriers is the primary focus of your work?

- Monopolies of knowledge

Which of the principles is the primary focus of your work?

- Democratize access

If you believe some other barrier or principle should be included in the mosaic, please describe it and how it would affect the positioning of your initiative in the mosaic:

This field has not been completed

Innovation

Define the innovation

We developed a simulation exercise called “CHAT” (“Choosing Healthplans All Together”) that allows variably educated populations who are inexperienced with health insurance to pick health benefits within a premium of INR 500 ($12) per household per year.

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Context for Disruption:

We brought to market a process that is simple to use and free-of-charge, enabling consumers to assert an interest in health insurance. This process disrupts the established approach to marketing health insurance ("take-it-or-leave-it") by enabling low-income clients to exercise choice where they had none hitherto, and on a complex issue as designing their health insurance benefit package.

By opening the possibility for choice, clients can determine how they wish to ration their spending on health insurance to reflect their perceived benefits (linked to expected health-seeking). Secondly, the clients can relate to risk mitigation as a tangible and affordable exercise, when until now health insurance has been viewed as a quasi-incomprehensible transaction that only experts could understand, in which the emphasis was put on rare events, limitations and other constraints that promised too little compensation and thus have been irrelevant for poor people. The disruptive character of our intervention is exemplified notably by the high demand we get from grassroots communities to bring CHAT to them.

The overwhelmingly positive results lead us to believe that CHAT can have a real impact on the development of health insurance amongst hundreds of millions rural poor in India and other developing countries.

Delivery Model

Our innovation requires us to organize groups to 'play CHAT'; the optimal group size is 15 persons, but we have organized groups as small as 12 and as large as 20. Each CHAT exercise lasts some two hours, and we bring along our copyrighted materials.

The local interlocutors provide the place where we conduct the CHAT exercise (e.g. a classroom, or simply under a tree – see photos) and help in organizing the people; the local group also provided one or several facilitator(s) who can speak English and the local language, and we communicated through the facilitators. Communication is verbal, but the process is guided by the facilitators’ manual to ensure that the process and the stages are followed in an identical manner in all locations and with all groups. This operative model has so far not allowed us to use distribution channels.

We now envisage developing a training module for facilitators so that the CHAT innovation can be spread more widely by people trained to do so. The training of facilitators will be done by the Micro Insurance Academy that has just started to function in New Delhi. Market penetration so far has been "experimental": we tested the tool, the interactions, the usefulness of the data we obtain. Now we are ready to take the innovation to the next stage, train facilitators, disseminate the innovation and respond to the considerable demand we have been getting from grassroots organizations to include them as well.

Key Operational Partnerships

CHAT was originally developed by the National Institutes of Health (USA), and adapted to the Indian context of low cost community-based health insurance through the Social Re project. It was tested in 124 villages in close cooperation with "Karuna Trust" (Karnataka), BAIF & Uplift Health (Maharashtra) and "Aapni Yojna Project" (Rajasthan).

The funding for the adaptation and field testing of CHAT was provided primarily by an EU (ECCP) project “Strengthening micro health insurance units for the poor in India” (www.microhealthinsurance-india.org) with support from the NIH and Hivos (www.hivos.nl/English) and in-kind support from the grassroots organizations.

As the innovation centers on community involvement and democratization of the process of designing health insurance benefit packages, partnerships are essential. The initial partnership between NIA and Social Re enabled the creation of the Indian CHAT materials, and resulted in several peer-reviewed publications. Funding from the EU enabled the initial field testing; a follow-up grant from Hivos enabled the launch of the world’s first Micro Insurance Academy that hubs the scaling of CHAT training and improvement. Finally, the grassroots organizations facilitate access to the end beneficiaries, who are at the heart of the process.

Impact

Financial Model

CHAT is the entry-point of our holistic approach to delivering low-cost community based micro health insurance. Within the overall scheme of health insurance operations, the costs related to running the CHAT exercises are absorbed in the insurance premiums. However, at the initiation point, CHAT is used as a tool to introduce communities to the value proposition of insurance, and therefore it is offered free-of-charge to communities.

CHAT is always tailored to local realities, which has proven as a very effective tool to make the insurance relevant for people with little or no prior knowledge of insurance to enlist to community-based health schemes. However, this customization requires upfront information about local needs, utilization and cost of care, which we have obtained up to now by carrying out baseline household surveys, which requires substantial investment of time and money (for data collection and analysis). To reduce the cost of CHAT further, we are currently working on modeling a modified and simplified intervention through assembling the information needed in a rapid access series of focus group discussions and key informant interviews.

The current interventions of CHAT, as well as the future modelling, are financed through several foundation and research grants, which recognize the great potential of the CHAT exercise in customizing the design of insurance solutions, enhancing the community-centered approach, and responding to context-specific needs of the poor based on local metrics, while reducing the cost of this process.

What is your annual operating budget?

£500'000.00

What are your current sources of revenue? (please list any sources that are foundation grants)

CHAT is currently implemented in India through the Micro Insurance Academy. The budget given refers to the Academy; it was recently launched with partial funding from Hivos (a Dutch NGO inspired by humanist values). Other sources of funding include research grants from (several) European research bodies.

Finally, the Micro Insurance Academy and its affiliated staff and linked partners have a wealth of experience and expertise in micro insurance, as well as excellent access to grassroots organizations. We have the technical know-how, the analytical ability, and the data needed to conduct diverse studies on micro insurance.
As such, we are uniquely placed to consult on a wide range of issues and policies relating to micro insurance, and we engage in consulting activities (mostly to international organizations and development agencies); income generated is used to cross-subsidize the capacity-building activities among resource-poor persons and communities in the field, including CHAT.

### Effectiveness

What has been the measurable impact of your project to date? How many people have benefited from your program in total? What policies, communities, or institutions have been influenced to make fundamental changes because of your work?

We evoke an assumption that when prospective clients become involved in selecting the services they will access through health insurance to reflect their perceived priorities, they will be more willing to join and pay for such insurance. Therefore, a method is needed to allow variably educated, poor populations who are inexperienced with health insurance to ascertain their priorities for insured benefits.

Never before has this been done in the context of health insurance in India/developing countries. We developed a modified version of the CHAT (Choosing Healthplans All Together) exercise tested previously among uninsured persons in the USA, and tailored the underlying metrics to the reality of several rural and semi-urban (slum) locations in India.

The ten benefit types that were included in the CHAT board reflect a synthesis of three sources of information: (i) published sources regarding health insurance in India (ii) utilization data from a household survey we conducted, and (iii) knowledge of the team regarding health services available locally.

At the end of the elicitation process, respondents were overwhelmingly positive about the experience, and upwards of 95% reported an interest to buy the insurance product they had just designed.

#### Which element of the program proved itself most effective?

The element of the programme that proved itself most effective was the receptiveness by the clients.

At the end of the elicitation process, respondents were asked about their satisfaction. Questions and responses were as follows:

- "would you recommend CHAT to others?" 98% answered yes;
- "would you be willing to accept the group’s choice of a plan?" 99% said yes;
- "how much would you trust a group of consumers using CHAT to design a health insurance plan for you or your family", 67% said “a great deal” and 28% said “somewhat”, while only 4% said “very little” or “not at all”.

This is corroborated in overwhelmingly positive answers to 12 other questions on fairness, clarity and relevance of the process.

### Number of clients in the last year?

In the past year CHAT was implemented in upward of 142 villages (in Maharashtra, Karnataka and Rajasthan) sample size: 2234 persons, representing a total population of some 200,000 persons.

### What is the potential demand?

Potential demand is as broad as the potential demand for health insurance among rural and poor persons in India (counted in at least 200 million persons), plus demand in other countries.

The completed CHAT exercises strongly suggest that this is the kind of entry-point activity that would be replicated in every place where health insurance is offered to groups (as distinct from individual marketing and sales).

As most poor persons live in tightly knit communities, the potential of CHAT to serve as the vehicle to give people choice in health insurance, and thus attract them to exercise sensible rationing of resources, based on local conditions and group experience, is universal.

Funding permitting, we will explore the demand also in Africa, where the notion of community and group-affiliation is also very strong, and where the potential demand for CHAT is also very promising.

### Scaling up Strategy

Our scaling-up strategy is based on three thrusts: (i) improve the instrument; (ii) expand activities in India; (iii) expand in other countries.

The potential of CHAT to serve both as a source of information about clients’ choices and as an advocacy tool to improve awareness among clients can be maximized when the metrics used to design the simulation exercise offer a faithful representation of the local reality. We have evidence of significant differences across locations in health needs, costs and supply, and as people are well placed to discern which benefits they will access through health insurance to reflect their perceived priorities, they will be more willing to join and pay for such insurance. Therefore, a method is needed to allow variably educated, poor populations who are inexperienced with health insurance to ascertain their priorities for insured benefits.

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The other scaling strategy is to perform the CHAT exercise routinely as the first stage of introducing health insurance among rural and poor persons. The initial field experiments have already created much more demand for the exercise than we could satisfy, in part because of the very enjoyable character of this group activity. We have established excellent links with networks of grassroots organizations and federations of NGOs, and through these links we can be introduced in many places across India. An additional phase planned for implementation within the next 3 years would be to bring the CHAT tool to other low-income countries.

### Stage of the initiative:

0
Expansion plan:
See answer under "Scaling up Strategy"

Origin of the Initiative
Repeated interactions with villagers and slum-dwellers in India, South Africa, and elsewhere gave us strong feeling that we were ineffective in communicating what health insurance is all about, and why it is good for poor people.

By chance, we fell upon a scientific article reporting on an experiment in the USA that used a game to elicit the choices of uninsured people regarding health insurance benefit packages. David contacted the Marion Danis (in NIH), explained what we wish to do in a completely different setting and a different target population… and our US contacts became our partners. Many conference calls later, we had a ‘new CHAT. And after more than a year of field experimentation, the greatest pleasure is to observe the great fun people have playing CHAT…

Sustainability

What are your two main challenges to finance the growth of your initiative
Changemakers webmaster: It seems that contrary to the indication on the website, this section is visible to the public. Therefore, we have opted not to fill it out. If you require more specific information, please feel free to ask.

How did you hear about this contest and what is your main incentive to participate?
Changemakers webmaster: It seems that contrary to the indication on the website, this section is visible to the public. Therefore, we have opted not to fill it out. If you require more specific information, please feel free to ask.

The Story

Do you have an annual financial statement?
Changemakers webmaster: It seems that contrary to the indication on the website, this section is visible to the public. Therefore, we have opted not to fill it out. If you require more specific information, please feel free to ask.

Do you currently have an annual financial statement that tracks profit/loss?
Changemakers webmaster: It seems that contrary to the indication on the website, this section is visible to the public. Therefore, we have opted not to fill it out. If you require more specific information, please feel free to ask.

Please describe the amount (and/or type) of funding you need to implement your initiative, at year 1 and at year 5.
Changemakers webmaster: It seems that contrary to the indication on the website, this section is visible to the public. Therefore, we have opted not to fill it out. If you require more specific information, please feel free to ask.

Source URL: https://www.changemakers.com/disruptive(entries/demystifying-health-insurance-package-design-choosing)#comment-0