

# BALANCING HEALTH MICROINSURANCE

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## ABSTRACT

Health Microinsurance is a controversial microinsurance product as it is the most demanded type of microinsurance amongst the poor while it is also the most technically difficult type of microinsurance because of high adverse selection, low quality of health infrastructure in developing countries and high operational costs. This study aims at contributing to the field of health microinsurance management by exploring the recent topic of performance measurement and long term balance between financial and social performance.

This is done by investigating how the delivery models of Health Microinsurance in India relate to performance measurement and affect the balance of social value and financial viability. In order to explore and explain the topic, the research starts by selecting the Mutual and the Partner agent models as representative of the common delivery structure of Health Microinsurance in India. The features of the two models are applied as parameters in the comparison of different performance measurement practices. The performance measurement is analyzed according to the 16 Key Performance Indicators created by the microinsurance industry, adding two more Health Microinsurance specific indicators.

As the literature indicates lack of academic review on the balance between financial and social performance and further lack of performance tools that combine both, this research realizes its main contribution to be presenting such framework to the Health Microinsurance industry. The Balanced Scorecard, adapted from Paul Niven since the social mission is the leading force for organizations that provide Health Microinsurance, incorporates the PACE model on client value and the financial viability methodologies.

The core argument of the study consists of two parts: 1) the type of delivery model affects the performance indicators that are measured and 2) there is a negative relationship between financial and social performance within both delivery models. In the case of the Mutual model, measures are monitored and interpreted in a social value light while the Partner-Agent model emphasizes the importance of viability through actuarial monitoring of financial performance measures. There is an overlap of financial and social measures but the different models interpret the results according to either more social or more financial performance. At the same time that creates a trade-off between outreach and better health benefits on the one side and financial viability and amount of subsidization on the other.

The paper's research strategy is constructed towards a multiple-case study design with qualitative methods as the primary technique. The core block of empirical data consists of data from five case companies that were selected for the model of their innovative scheme and the outreach of their operations. The outcomes of the study point out at substantial differences between the two delivery models but also significant differences among the organizations' performance practices.

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## INTRODUCTION

### Introduction to the problem

Currently, India has the most dynamic microinsurance sector in the world (Allianz, 2006; Microinsurance Network, 2011). Over the last few years new schemes are mushrooming all over the country promoted by a wide variety of actors. More and more international donors persuade their local partners to start community health microinsurance programs for their target populations. Micro-finance institutions and banks, on the other hand, design insurance schemes with obligatory membership of their lenders with the ultimate goal to ensure the reimbursement of the loans. The latter movement was provoked by the social and rural obligations established by the Insurance Regulatory and Development Authority (IRDA) in the Micro-Insurance Regulations 2005, in which the for-profit insurance companies are encouraged to venture into this sector. In this way technical expertise became available and very soon showed its effects in terms of constant products improvements and innovations (USAID, 2008 and von Menon, 2006). The key distinctive feature of the Indian experience for the provision of adequate health protection benefits to each and every citizen appears to be the diversity of actors, target groups, distribution channels, financing mechanisms and operational modalities. With these very unique features, there is no arguing that India had already taken the lead and deserved to be seen as the *health microinsurance laboratory of the world* (ILO, National Review 2009).

Health Microinsurance can be defined as a type of health insurance that is being provided to individuals or families who are unable to afford the traditional health insurance schemes existing in the market. These special health insurance schemes are meant for people usually living below or just above the poverty line and are provided both by government and private players, through low premiums and affordable prices for health services. It is a risk-sharing mechanism that lowers the out-of-pocket expenditure for medical care through higher utilization by scheme members. Almost four-fifths of the health spending in India is private, out-of-pocket expenditure (IRDA 2007) and it is estimated that out-of-pocket spending on hospital care might have raised the proportion of the population in poverty by 2 per cent (The World Bank, 2005). Risk-pooling and collective purchasing mechanisms could increase the efficiency and equity with which the households' money is collected, managed and used, so that the households' burden is reduced (WHO; World Bank; Ruchismita, Ahmed & Rai, 2007). However, only about 25 million persons are presently covered for health through commercial insurance, in a country of over 1.1 billion people. Overall, the Indian health sector is still characterized by the near absence of any significant risk protection against major health-related expenditure, which barely constitutes a tenth of all health expenditure in the country (IRDA 2007). "*India presents an opportunity as the level of penetration of insurance is very low,*" said Jim Roth, co-founder of the double bottom line investment company, Leapfrog, looking to deploy as much as \$40 million in India (WSJ, 2010). Thus, the Indian health insurance market represents a great untapped opportunity.

Lately health microinsurance has become the product for which there is the greatest demand among poor and low-income households (5th International Microinsurance Conference, 2009); however despite their increasing presence, these schemes have not been able to become sustainable in the long run. Microinsurance is a highly technical

operation. It is a low-price, high-volume business and its success and market sustainability is dependent on keeping the transaction costs down. While healthcare financing is still an enormous challenge; even sophisticated markets and governments of developed countries are struggling with it; there is an increased interest in how new health microinsurance approaches might provide key opportunities for countries and donors as they strive to reach their Millennium Development Goals.

## Problem Statement

Despite the fact that recent discussion focuses on the need for microinsurance programs to become viable; that is, these programs need to stop relying on short-term funding via subsidies; little academic attention has been paid to this market. Even though health microinsurance is one of the most researched and tested areas of microinsurance in India (Magnoni and Zimmerman, 2011), performance management in relation to the double bottom line has hardly been discussed in the literature. As performance management is realized to be an important and a central discussion at present this research aims to contribute to it.

Although the World Bank identifies health microinsurance as an important complement to poverty reduction efforts, it is one of the most notoriously difficult microinsurance products to implement, because it requires significant managerial expertise. The services are usually provided by a third party and this makes it challenging to ensure good quality, control service cost, prevent fraud, overcharging, or excessive utilization. On one hand, prices of health insurance products should continue to be affordable to ensure wider acceptance and increased reach, while on the other, the insurance industry requires that this line of business remains commercially viable. However, a majority of the schemes do not possess the hindsight and experience needed for an accurate determination of the financial risks they face (Biswas & Devi, 2006). Thus, the need for presenting a management tool that can monitor the balance between the financial and social performance of the schemes and avoid a trade-off.

Indeed, traditional grant-finance might cause problems, like the risk of crowding out existing investment plans of companies, or pushing them into problems they cannot sustain over the long term. Grant-based projects that run for a year or two might even harm the development of microinsurance markets in the long term (Nextbillion, 2010). In the absence of this source of funding, such programs will be subject to the same economic and market forces experienced by commercial insurers. There is already pressure by foreign institutional investors like LeapFrog who strongly rely on a market-based approach to microinsurance and are increasingly willing to assess both the financial and social returns of the delivery organizations. This again requires microinsurers to be managed professionally. Professional management, however, calls for transparent performance measurement. As a first step toward developing transparent performance measurement processes, the Microinsurance Network has set up a Performance Indicators Working Group and has initiated the development of 10 financial performance measures in 2005.

As many health microinsurance programs are set up as nonprofit schemes and social organizations, often their objectives are not limited to financial performance. The social function of microinsurers, that is, providing protection against specific perils, and thus, facilitating economic growth and mitigating poverty, inequality, and vulnerability, is a

crucial aspect in evaluating their performance (Biener & Eling, 2011). Getting the economics right is difficult, therefore besides only looking for "*strong positive returns*", Leapfrog will seek to apply social criteria in their interaction with their investees (Nextbillion, 2010). In that spirit as a second step 11 indicators on social performance were revealed in 2010 through a workshop organized by the same Performance Indicators Working Group of the Microinsurance Network. It should be pointed that many of the existing performance measures overlap in providing social and financial value. Further assessment of performance, however, needs to provide a framework for combining social and financial performance indicators through a more holistic framework than simply listing them in logical order with the use of basic data analysis principles.

If the need for financial and social performance is clear, the means to deliver it remain work in progress. Besides the above mentioned initiatives, there is limited consensus on which tools, not to mention which organizational model, remains most apt for fulfilling the promise. This research argues that the need to establish clarity on such matters is pressing. If Health Microinsurance is to avoid a nosedive into accusations of mission drift like the ones microfinance is currently dealing with (Pim Engels, 2010), even at this early stage, it is important to build up social performance management at the same time as the know-how for financial sustainability is built up. The primary assumption of this research is that there are performance differences and needs between the delivery models of Health Microinsurance and those should thus be considered when creating a performance measurement tool for health microinsurance.

To structure the paper around the research topic, the author defines the problem statement as:

*How can performance in Health Microinsurance in India be managed in order to achieve long term balance between financial and social performance?*

Formally the problem statement indicates the following sub-questions:

1. *What are the delivery models of Health Microinsurance in India?*
2. *How is performance managed by the different delivery models at present?*
3. *Why is there balance or trade-off in the performance of Health Microinsurance in India?*
4. *How do the model specifications influence social and financial performance?*

Performance measurement in this research is defined as an evaluation of the past activities with respect to the desired strategic goals. Ultimately, this research aims to find empirical evidence on the performance measurement practices of Health Microinsurance organizations in India and on the occurrence of performance trade-off as well as to provide an insight of the need for balancing financial and social performance in India. The core argument of the thesis is that a holistic approach is required to aid Health Microinsurance respond adequately to the health needs of the poor while operating through market mechanisms. The overall goal is not to provide ready-made prescriptions that are ready to be applied but rather to define building blocks which a manager can use to assemble a performance measurement tool, taking into account the specific delivery model characteristics. In order to provide a deeper

understanding about the research issues, this paper follows the performance measurement practices and the market developments of health microinsurance and explains the relation between those. The research takes into account the perspective of the management of HMI organizations and by so doing it concentrates on ways to develop their performance management practices. Health Microinsurance organizations are chosen as the research unit because of the high importance, high demand and at the same time numerous challenges to management in Health Microinsurance. The theoretical backbone of the study lies with welfarist and institutionalist line of theoretical thinking as well as with performance management tools used in Microinsurance, PACE, and borrowed by general performance development, the Balanced Scorecard.

## Structure of the research

The following *Chapter 2* provides an introduction to health microinsurance in India which is presented through the prism of its dual function of a social protection mechanism and a business opportunity. *Chapter 3* investigates the models of HMI delivery that are typical for the Indian market; the characteristics, design, context, strengths and weaknesses that are expected to influence their performance measurement practices. *Chapter 4* explores the measurement methodologies of the financial and social performance adopted by practitioners and enablers of microinsurance. Here, the key performance indicators for microinsurance are presented in relations to Health Microinsurance. Moreover, the adoption of those measurement practices is discussed by presenting recent studies of different models. *Chapter 5* discusses the performance related literature in Health Microinsurance that has evolved around the debate between institutionalists and welfarists on the assessment of utilization, outreach, scope, cost reduction, viability and client value and the trade-off among those parameters in designing health microinsurance schemes, which relates to the balance of social and financial performance. A holistic tool that is sensitive to microinsurance issues and that can be applied on monitoring, managing and balancing performance is proposed. Such a tool or system is inspired by the Balanced Scorecard and includes the industry performance measures and the methods to assess those as suggested by the PACE model. In *Chapter 6* the problem statement is structured into four hypotheses and illustrated by the research model. Further on, the research approach, strategy, limitations and validity and reliability are suggested. *Chapter 7* analyses the five cases and the data collection as well as the characteristic of the empirics in relations to social and financial performance. The structure of the analyses is borrowed from the Balanced Scorecard as the model is characterized by the provision of performance balance in the long term. The chapter concludes with implications to the hypothesis and the reason for performance trade-off in Health Microinsurance. *Chapter 8* provides a general conclusion to the research. In addition, the chapter discusses the limitations of this research, and provides recommendations for further research.



## HEALTH MICROINSURANCE

### Health Microinsurance at a Glance

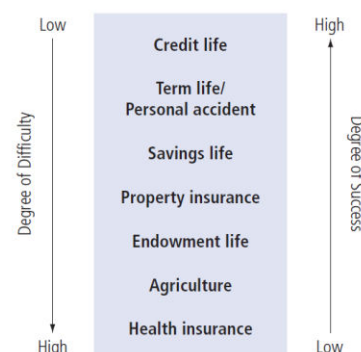
Microinsurance is a form of health, life or property insurance, which offers limited protection at low contribution (hence 'micro'). It is micro in two ways— their claim load is small, and their turnover is marginal compared to the volume of the formal insurer. It is aimed at the poor sections of the population and designed to help them cover themselves collectively against risks (hence 'insurance') (Microinsurance Academy, Dror and Jacquire, 2007). In line with this, health microinsurance is primarily a phenomenon offered to improve access to health care for the poor in developing countries, partly because insurance penetration is low and government social protection schemes only cover a small minority of citizens. Health Microinsurance is a risk-sharing mechanism that lowers the out-of-pocket expenses for medical care at the time of purchase by smoothing medical payments across individuals and time (Schneider 2004).

In order to serve the socially and economically disadvantaged, insurers have to think differently – about customers' needs, product design, delivery systems and business models. Microinsurance policy in India is not simply low-premium insurance and differs from health insurance in several ways (see ANNEX I). In case of a poor individual, the size or the extent of insurance coverage is not a choice variable. Individuals cannot choose coverage level at a given price or decide on the risks against which to buy insurance, as is generally the case with health insurance. The poor are offered an insurance package that includes price, benefits and defines the method of paying premium and settling claims. All that they decide is whether or not to join the scheme. Price is based on community rating and not on individual rating. Health insurance in case of the poor is generally a group contract mediated through or managed by a nodal agency. In case of health insurance for the poor, some level of subsidy or external funding is necessary for ensuring sustainability of schemes. According to the ILO inventory, most of the schemes receive a financial assistance to initiate their activities (Ahuja, 2005). This gives rise to a number of issues such as the appropriate size and source of subsidy.

Moreover, health insurance does not remove all financial barriers to access health care. Often there are many indirect costs such as wage loss, transportation costs, incidental costs during hospital stay and so forth. This is not to suggest that people who are not poor do not have to bear these costs. What distinguishes the poor from non-poor is that these costs often prevent the poor from seeking medical care. So, a careful design of scheme must try to minimize these other financial as well as non-financial barriers. Furthermore, mechanism of premium collection and claim settlement itself can act as a barrier to join a scheme. A flexible method of collecting premium is needed for people who have low and fluctuating income. Similarly, prompt claims settlement in case of the poor who lack credit facility assumes special significance in case of the poor. The design of health insurance system involves strengthening health care provision as well. Providing health insurance is meaningless if the health facility is weak. A weak facility dissuades individuals from joining the scheme and this also has a bearing on the cost of illness. So initiating health insurance in case of the poor also involves strengthening the supply side (MicroEnsure, 2009).

Consequently, Health Microinsurance has emerged to fill the gap from several parallel entry points of delivery. First, to cope with health risks, many low-income persons form their own mutual benefit associations. Some of these unregulated community-based insurance schemes have grown quite large, posing a dilemma for regulators. Second, some development agencies, like the ILO and MicroEnsure, have encouraged persons excluded from commercial and social insurance schemes to create risk-pooling mechanisms. The ultimate intention of many of these donor-led efforts is to link them to government support in order to facilitate a redistribution of resources from the rich to the poor. Third, with encouragement from MFIs and regulators, some insurers see the vast number of low-income persons in developing countries as a new market opportunity (Churchill 2007). This perspective is articulated by Prahalad in his book *Fortune at the Bottom of the Pyramid* (BOP) and supported by findings from the latest research on microinsurance trends among commercial insurers (Micro Insurance Network, 2011). However, due to lack of awareness, knowledge, and inflexibility and uncertainty about benefits, potential clients find it difficult to approach formal insurance companies. At the same time, due to higher transaction costs of marketing and servicing insurance products, relatively low returns assured per policy, and lack of proper technology and required institutional framework, the formal insurance companies are not able to reach these clients (Basargekar 2010). Thus, commercial insurers in India partner with delivery agents in order to provide Health Microinsurance. However, some argue that this type of insurance should not be commercially sold, but rather be considered a natural right as part of a government's social protection program (Churchill, Morduck, Will de Klerk).

Despite their increasing presence and great demand among low-income households, health microinsurance schemes have not been able to become sustainable in the long run and suffer from several limitations: (1) a third party is necessarily involved (for example, the health care provider); (2) a number of classical insurance problems apply (those more likely to get sick are also more likely to sign up, those who are insured are more careless and overuse health services), which makes insurance costly for all involved; and (3) the only policies that are affordable to poor people are those that are highly restrictive in terms of the kinds of benefits offered. Designing valuable, sustainable products is inherently more complex for HMI than for other types of microinsurance (see Figure 1), because for one, it requires significant managerial expertise. Most HMI



**Figure 1: Positioning Health Microinsurance; Source: Churchill, Microinsurance Products**

products cover catastrophic risks which occur with low frequency, are often unpredictable, and result in a need for high-cost services, such as hospitalization. These catastrophic events are more easily insured than routine healthcare needs, so insurers have focused on them, often designing in-patient only coverage. However, HMI programs struggle to reach sustainable membership for these in-patient policies, partly because the poor perceive more value in coverage for high frequency, predictable and often low-cost services (ILO, No. 6). Thus, add-on out-patient services are an incentive for buying and renewing health insurance. Moreover, community health workers can improve health-related outcomes of low-income households. Technology-leveraged quality healthcare at the doorstep in villages will

bridge the infrastructure gap in rural areas and deal with the supply side issues in the healthcare system in India (6<sup>th</sup> International Microinsurance Conference, 2010; Will de Klerk).

### Social Protection Mechanism

Thus, microinsurance is loosely described by many as a risk management and social protection mechanism for the economically disadvantaged. However, social protection is not necessarily the same as microinsurance and not all microinsurance programs provide social protection (Biswas & Devi, 2008; Garand & Wipf, 2010). According to the World Bank social protection is “[it] is a set of interventions that assist individuals, households, and communities (i) to better manage economic risk, and (ii) to provide support to the poorest and most vulnerable”. For the purpose of this research health microinsurance is considered to have a social protection function and “should not only be evaluated on technical aspects (e.g. financial viability), but also on their capacity to reach social protection outcomes; the social-economic impact of these schemes on members and non-members should be taken into consideration” (Jacquier et al, 2006, p.46).

Within the social protection framework, the literature provides good evidence that community financing arrangements through Mutual organizations make a positive contribution to the financing of health care at low income levels. In doing so, such arrangements improve people’s access to drugs, primary care, and even to more advanced hospital care. This community involvement allows rural and low-income populations to raise more resources with which to pay for health care than would otherwise have been possible. Risk-pooling and collective purchasing mechanisms could increase the efficiency and equity with which the households’ money is collected, managed and used, so that the households’ burden is reduced (Ruchismita, Ahmed & Rai, 2007). The social protection mechanism is also linked to the Partner-Agent delivery model for Health Microinsurance as illustrated by Figure 2. Thus, social protection is the core of Health Microinsurance (4<sup>th</sup> international microinsurance conference).

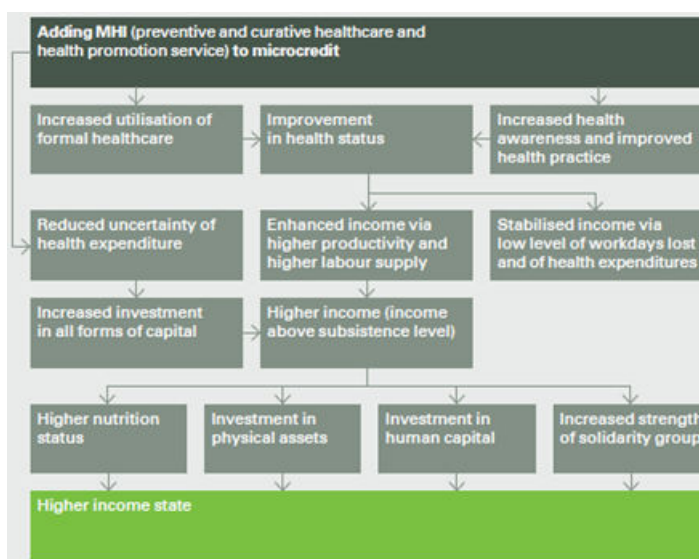


Figure 2: A model of the relationship between health microinsurance and income; Source: 5th International Microinsurance conference (2009)

However, vulnerable people need protection not only against the economic livelihood shocks caused by the catastrophic health expenditure but also against exploitation, abuse and social exclusion that they experience within the health system. Depending on their management design and financial structure HMI can also play an important role in respectively the empowerment and participation of their members, and social equity and solidarity. Health insurance schemes should therefore be approached for more than their economic protection role. They can trigger

transformations in the socio-institutional structure in at least three ways: 1) insured women will not depend that heavily anymore on the men for financial resources and a membership can boost their self-esteem; 2) create a sustained and effective bottom up pressure from interest and community groups representing the poor, building “bridges” across communities and social groups; 3) evolvement towards a universal system of social health insurance. HMI schemes then develop opportunities to act as brokers as they form strategic connections with other stake holders working on health policy (Joris Michielsen).

Many studies suggest that HMI is effective in reaching a large number of low-income people who would otherwise have no financial protection against the cost of illness. At the same time several studies demonstrate that the bottom 20 percent of the BOP cannot be feasibly insured through market mechanisms because schemes are not able to reduce the financial access barrier enough (Jakab, Preker et al, 2001; ILO, No.6). However, there are some examples of HMI schemes that show how financial barriers can be overcome even in a very poor context as is the case of PREM in India. Such finding indicates that certain design and implementation features allow poor communities to overcome the inability to pay. Donor support and government funding present a key to initial sustainability (Perker, Carrin, Dror et al, 2002). Nevertheless, it is only skillful and competent management with strong involvement and ownership of the community that is able to sustain a health microinsurance scheme in the long term and contribute to financial protection and social inclusion.

### Business Opportunity

According to MicroSave (2010) the potential market size of Health Microinsurance in India is 15.39 to 17.89 Rs billion per year, listed as number two after life microinsurance. However, despite this reality, only 0.46% of India’s population has health insurance (Dror, 2007). According to a recent study by the McKinsey group, rural insurance penetration is only 25 %, and insurance penetration among low-income groups in urban areas is 30 % (see Figure 3). Some recent estimates by reinsurers suggest that health insurance is likely to grow rapidly, cover 20% of the population and constitute 12% of the total health market of the country, or over 30 Rs billion by 2015. This makes it clear that there exists an untapped potential for insuring the uninsured.

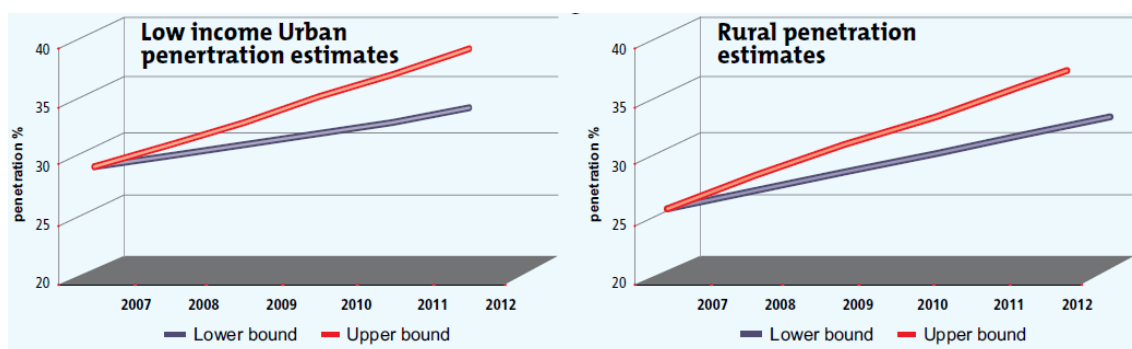


Figure3: Health Microinsurance Penetration in India; Source: Dror, 2007

The demand for health insurance covers has seen a healthy increase, and today the sector is the fastest growing segment in the non-life insurance industry in India (IRDA). However, still almost four-fifths of the health spending in

the country is out-of-pocket expenditure. In the absence of such health protection, the financial impact of hospitalization can be very pronounced, and indeed is reported as one of the leading causes of impoverishment in the country. Thus, there can be no doubt that health insurance is a *need* and a *potential* that requires yet to be addressed.

Health Microinsurance is a highly technical operation. It is a low-price, high-volume business and its success and market sustainability is dependent on keeping the transaction costs down (Allianz, 2006). Claims handling is expensive because of the large numbers of cases. Access to healthcare and/or quality of healthcare may be poor in a particular country, which limits the value of any health insurance provided. Other problems that are expensive to control are fraud, both by those insured and healthcare providers; as well as moral hazard and anti-selection (LLOYD'S, 2009). The services are usually provided by a third party and this makes it challenging to ensure good quality, control service cost, prevent fraud, overcharging, or excessive utilization. Thus, commercial insurers do not offer health insurance unless it is accident related (Micro Insurance Network, 2011).

On one hand, prices of health insurance products should continue to be affordable to ensure wider acceptance and increased reach, while on the other, the insurance industry requires that this line of business remains commercially viable (IRDA). To overcome this, it is important to continuously accumulate clean and accurate claims and exposure data for analysis and monitor in order to rapidly detect any unfavorable trends. Trends in both frequency (incidence) and in claim amounts should be monitored separately for each benefit category. Analysis of claims at the level of each service provider could help detect provider abuse and inappropriate treatment (Garand and Wipf, 2010). Systematic and regular monitoring of performance by the insuring organizations is of high importance, especially, considering the variety of issues that the organizations have to overcome (see Table 1). Integrating risk management practices in the strategic planning process is necessary for a highly technical HMI scheme to succeed (Rademacher et al., 2009; Andersen & Schröder, 2010). According to Biswas & Devi (2008), however, the majority of HMI schemes do not possess the hindsight and experience needed for an accurate determination of the risks they face.

Issue Category	Subcategory	Specific Issues
Strategic	Management ability	Adverse business decisions
		Improper implementation
		Liquidity (cash flow management)
	Performance	Generate double bottom line results to attract investors
		Transparency
	Governance	Responsiveness to changes in the business environment
		Board consistency and direction

<b>Operational</b>	Internal business processes	Service quality
		Claim formalities
		Unclear procedures
		Employee / client communication
	Technological	MIS development
		Database failures
<b>Financial</b>	Market	Providers and service charges
		Split-care market
		Demand and client education
		Maturity (lack of previous data)
		Moral hazard
		Adverse selection
<b>Social</b>	Donors	Improper subsidizing
		Exit of donors
	Value systems	Trust and reputation
		Fairness
	Class and cast	Elite capture
		Homogeneity
		Illiteracy
<b>Human Resource</b>	Organized collective action	Communication patterns
		Lobbying
	Employees	Training
		Incompetency
		Negligence
<b>Legal</b>	Providers	Qualified doctors
		Service quality
	Political structure	Donor support
		Access to a formal legal system
<b>Legal</b>	Policy	Innovation
		Consumer protection
		Access to funds

*Table 1: HMI Issues Related to Performance Measurement; Source: Bradbury, Ray (2010); Rademacher, Roberts Singh & Srivastava (2009), Weber (2002)*

It is important to recognize that insurance is neither the sole means available, nor necessarily the most desirable option for the poor when it comes to addressing risk. While some argue that insurance is difficult for people with little formal education to grasp as a concept, selling insurance is complicated by the need to convince a poor household to part with hard-earned savings for a future event that might not materialize. The contrast of microinsurance with microcredit helps to see the difference between these two microinsurance activities. In the latter, money is offered first, and then lenders have to find ways of ensuring that clients repay the loan – lenders have to find ways to ensure they can trust that repayment by clients will take place. In insurance, clients first part with their money, and then they have to trust the insurer that they will indeed get money (or a service, such as health care) when problems arise. Insurers have to be trusted by clients (Radermacher et al., 2006). Trust can be built by education, building on existing structures, or through careful marketing and sales strategies. McCord (2008) underlines that a fine balance is required between acquisition of new technologies to decrease costs and human contact to educate policy holders and build trust. Despite its importance, there is little systematic knowledge about instruments and mechanisms to build trust (Schneider, 2005). In the experience of Francis Sommerwell, Microcare *“it takes a lot of time before ... people will trust a product. However once you have a successful and trusted product, word of mouth and testimonial marketing work effectively.”* (LLOYD’S, 2009).

## DELIVERY MODELS

Health microinsurance is mainly prominent in community-based systems because health risk is generally seen as potentially the most devastating type of systemic risk likely to upset the lives and economic livelihoods of the low-income population (CGAP, 2009). Despite their frequency in microinsurance, organizations with collective ownership, Mutual organizations, face competition from other models where the primacy of the client, or member, is not guaranteed (Roth et al, 2007). As Health Microinsurance finds its own rhythm, it is important, to explore which delivery models help keep the client at the center while paying attention to questions of sustainable performance. The stakeholders in organizing HMI are grouped and illustrated by Figure 4. This paper intends to analyze the most popular models of HMI in India which includes both regulated and informal insurers. The discussion of performance measurement, however, is kept at organizational level and does not include the whole delivery chain.

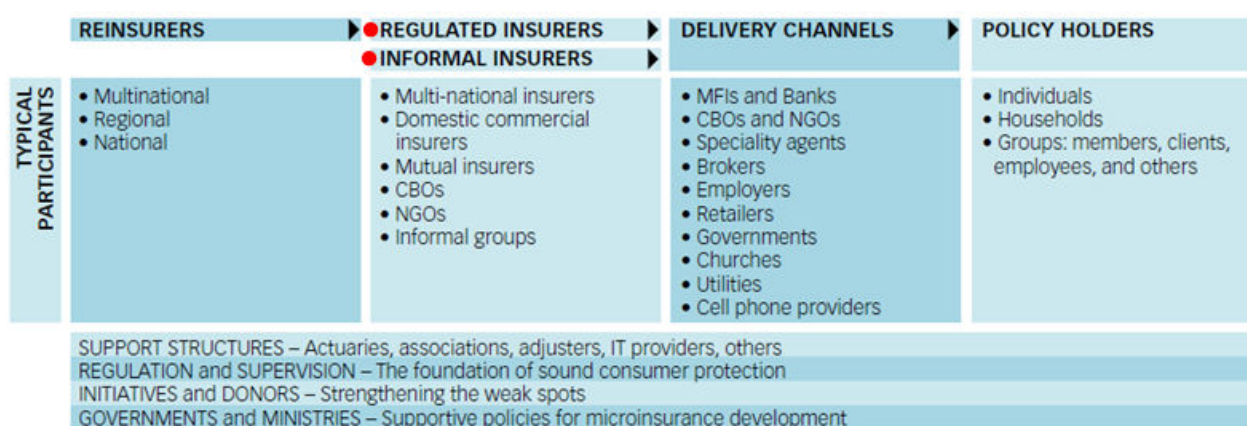


Figure 4: Key Players in Microinsurance; Source: LLOYD'S Insurance in Developing Countries

Health Microinsurance is a new field and there is limited evaluative evidence on the performance of different delivery models on both social and financial indicators. There is ample practical evidence, however, of good and bad practices that contain important lessons (CGAP, 2009). Drawing from these experiences, the success of microinsurance is centered on the following factors:

- the products must be demand-driven and respond to the needs and abilities of the low-income market
- the products and processes used to deliver insurance must be efficient
- the institutions providing coverage must offer adequate protection to policyholders and manage their risk and long-term solvency

The different institutions involved in HMI vary in the degree to which they meet these criteria or experience trade-offs. For example some institutions have a high level of efficiency but may not offer products that consumers truly value. As illustrated by Table 1, a variety of factors can influence the client value and effectiveness of insurance, including the ownership structure of the risk carrier, the extent to which policyholders are involved in designing or managing their insurance, the risk-management capacity of the institution, and the degree to which it is regulated (Chandani, 2009). Table 2 provides an overview of the business processes and structures of the two models chosen for discussion in this paper.



Models	Partner-Agent (Type III)	Mutual (Type II)
Examples	MicroEnsure; BASIX; Mahasemam	PREM & UpLift
Role	<ul style="list-style-type: none"> <li>Plays role of agent</li> <li>Purchase care from providers</li> <li>Purchase insurance from commercial insurers</li> </ul>	<ul style="list-style-type: none"> <li>Plays role of insurer</li> <li>Purchase care from providers</li> <li>Provide insurance</li> </ul>
Basic motivation	<ul style="list-style-type: none"> <li>Profit (for the insurer)</li> <li>Coverage for the target group (for the agent)</li> </ul>	Reduce the long term cost of health risks for members
Manufacturing	Rare events (hospitalization) that represent fewer, larger claims to keep transaction costs low	Optimal balance between benefits and premium for the members
Sales	Use of agents (MFIs, CBOs, NGOs) to enhance proximity and ease of payment	Use of existing community structures (SHGs) and involvement of members
Servicing	Reduce fraud and negotiate on scale with supplier to drive down costs	Reduce fraud and negotiate on scale with supplier to drive down costs
Sustainability	Price products correctly; achieve a sufficiently large group size and risk diversification	Price products correctly; achieve a sufficiently large group size and risk diversification; prevent members from divesting reserves from future years
Nature of management	Professional managers who report to the board	Management by local communities who lack insurance expertise

*Table 2: Delivery Models of Health Microinsurance; Source: Goldberg & Ramanathan, 2007; Rademacher & Dror, 2006; Ahuja, 2005; Bhat & Jain, 2006*

According to Bath & Jain (2006) and Ahuja (2005) there are three basic designs of HMI, depending on who the insurer is. In Type I (or provider model), the hospital plays the dual role of providing health care and running the insurance program. This model is not of interest to the research. In Type II (or Mutual model), the voluntary organization is the insurer, while purchasing care from independent providers. Finally, in Type III (or Partner-Agent model), the voluntary organization (NGO, MFI) plays the role of an agent, purchasing care from providers and insurance from insurance companies. The latter two models seem to be the prevailing in India.

#### *Partner-agent Model*

As the name implies this model involves a partnership between an insurer and an agent that provides financial services to large numbers of low income people. The partnership model uses the comparative advantage of each partner so that each can focus on its core business: the insurance provider is responsible for designing and pricing the product, the final claims management, and the investment of reserves, and absorbs all the insurance risk. In addition to selling the policies, the agent offers its infrastructure for product servicing such as marketing, premium collection, and assists in claims management (Allianz, 2006). For health microinsurance, in addition to the partnership with an aggregator a medical service provider and a TPA for administering service claims are also involved (see Figure 5).

The Partner-Agent Model is promoted by IRDA legislation. However, it faces several challenges. Because of IRDA's inadequate definition of an agent, most agents are not recognized and are treated with neglect. The restriction to only one life and one non-life partner limits the viability of microinsurance as a business opportunity, as it does not provide the right combination of products to clients. Furthermore, the insurance companies appear to provide much of their government designated "quota" of microinsurance to rural customers at a loss in order to be legally compliant, and once they have achieved their quota they stop trying to sell more (Allianz, 2006). An overarching

problem may also be a conflict of interests between a profit-seeking commercial insurer and the broker organization, like MicroEnsure, which represents insured clients rather than acting as an agent and representing the insurer. Such conflict is due to limits in product design and inability to launch more complex products.

Another issue is the low level of engagement of MFIs due to small earnings. Richard Leftley, CEO of MicroEnsure, confirms that MFIs are not willing to undertake health microinsurance due to low earning (a loan brings a profit of 10 USD, while insurance brings only 0.20 USD). It is also critical that the finances and management of the insurance business are separated from the MFIs' savings and credit activities. The reason for this is partly because the microinsurance product could have high transaction costs and because of the difficulty in controlling moral hazard and adverse selection.

### Mutual Model

The mutual model works as a community-based health insurance which is defined as any not-for-profit insurance scheme that is aimed primarily at the informal sector and formed on the basis of a collective pooling of health risks (Devadasan & Nadraj, 2006). The model is based on the original historical idea of insurance, which was initially insurance provided by mutual liability institutions to a limited member base. In this model an NGO provides health microinsurance to its members directly and the risk is not necessarily passed on to an insurance company (see Figure 6). These are referred to as in-house insurance providers.

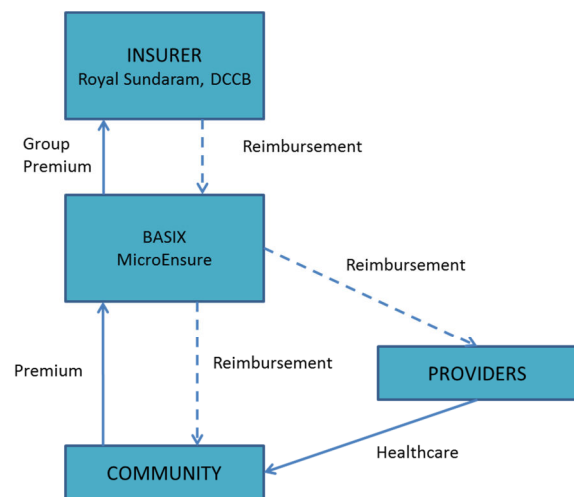


Figure 5: The Partner-Agent Model

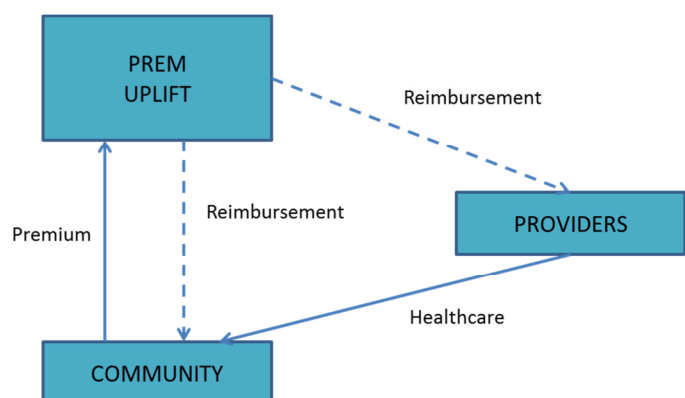


Figure 6: The Mutual Model

According to the World Health Organization, Dror, Preker(2002), Jakab (2001), and Chandani (2009) there are several common features affecting the success of community-based HMI schemes:

- Active involvement of the community engaged in mobilizing, pooling, allocating resources for health care, and scheme management;
- Ability to address adverse selection and rent-seeking provider behavior through revenue collection and purchase of instruments;
- Durable relationship between the scheme and providers to achieve better value for members' money;
- Sustained donor and/or government support;
- The beneficiaries of the scheme have predominantly low income;
- The schemes are based on voluntary engagement of the community (although not necessarily of the individual community members);
- The structure of resource mobilization and benefits reflects the principles of solidarity and cohesiveness and the motivating force is not profit but welfare-oriented
- Provision of additional health-related services.

Jakab, Preker et al (2001) confirm that inclusion is not an automatic outcome of community structures. This suggests that certain scheme design and implementation are important to achieve pro-poor targeting. Thus, monitoring of performance patterns is essential to ensure inclusiveness.

### Comparison of the Models

Table 3 provides an overview of the strengths and weaknesses of the two models, followed by a short discussion of their performance practices.

	Partner-Agent Model	Mutual Model
<b>Strengths</b>	<ul style="list-style-type: none"> <li>• Large number of households covered</li> <li>• Great percentage of health risks covered</li> <li>• Financially stable</li> <li>• Legally recognized</li> </ul>	<ul style="list-style-type: none"> <li>• Efficient in identifying community needs</li> <li>• Low moral hazard and adverse selection</li> <li>• Low transaction cost</li> </ul>
<b>Weaknesses</b>	<ul style="list-style-type: none"> <li>• High possibility of fraud</li> <li>• Conflicts of interest in the financial-nonfinancial mix</li> </ul>	<ul style="list-style-type: none"> <li>• Small number of households covered</li> <li>• Small low caliber risks</li> <li>• Financially unstable</li> <li>• In legal vacuum</li> </ul>

*Table 3: Summary of Pros and Cons of the Two Delivery Models*

Claims management is usually much better in a Mutual model. As field staff is usually taken from the group of insured, some might be persuaded not to use services for the sake of stability of the entire scheme (Rademacher, 2010). The risks covered are also more comprehensive, and more customized. However, the Partner-Agent model is considered to be more financially stable because the risk is retained by a formal insurer and in case of systematic risk, i.e. epidemic, it is highly probable that the Partner-Agent model will be able to handle the risk much better.

It can be argued that a first comparative advantage of Mutual over Partner-Agent is that their members are less vulnerable to moral hazard. Indeed, they are incited to share their knowledge about the behavior of their peers in order to avoid paying for the misconduct of others. The second comparative advantage of the Mutual is its good possibilities to reduce the risk of adverse selection by exerting social pressure to subscribe whole families to the insurance scheme. This ensures that there is a balance of good and bad risks in the portfolio. The third comparative advantage is that the Mutual model can be expected to have lower transaction costs. Since premium collection and claims processing are dealt with locally, the Mutual does not have to spend money for a special sales force or for commissions. Also, the Mutual can operate with philanthropic staff that works for relatively low salaries or even on a voluntary basis. Fourth, Mutuels have a lead in addressing the immediate health concerns of the members. The relation between contributions and benefits can be adjusted to members' preferences, while there are no external shareholders who have to be satisfied with profits. Furthermore, it is not uncommon that Mutuels provide complementary services to members such as health education or negotiations with hospitals to obtain discounts for treatment (Haensel, 2010).

Nevertheless, the financial viability of Mutuels may be endangered by a lack of risk-management skills and limited management capacity. For example, contributions may reflect members' ability to pay rather than the cost structure of the benefits. It is tempting for managers to expand their insurance scheme but this often does not benefit the members. With growing size of the insurance scheme, managers tend to lose focus on the members and members rarely have the skills to control them effectively. The missing access to reinsurance adds to this problem and makes the schemes vulnerable to covariant risks impinging simultaneously on a large group of people. Also, it is much more difficult for Mutual schemes to raise equity funds than it is for stock companies because equity can only be raised from members. This may obstruct a process of expansion which is crucial to reach better portfolio diversification. Some Mutual schemes even depend on subsidies to cover their operational costs. Regulators may refrain from recognizing such organizations whose financial sustainability depends on the benevolence of a donor (Haensel, 2010). Another merit of the Mutual model is the aggregating role and the context specificity that the NGO/CBO assumes.

Thus, the main strengths of community financing schemes are the degree of outreach penetration achieved through community participation, their contribution to financial protection against the cost of illness, and the increase in access to health care they afford low-income rural and informal-sector workers (Jakab and Krishnan, 2001). Their main weaknesses are the small amounts of revenue that can be mobilized from poor communities, the frequent exclusion of the very poorest from participation unless subsidized in some way, the small size of the risk pool, the limited existing management capacity in rural and low-income contexts, and isolation from the more comprehensive benefits

often available through more formal health financing mechanisms and provider networks (Dror & Perker ,2002; Jakab, 2001).

Finally, many of the schemes see health insurance as an end in itself. However, it must be remembered that health insurance is a means for a more equitable and functional health system (Devadasan & Nadraj, 2006). Despite its weaknesses Mutual HMIs can be the best model in the case of a national roll out as it will capture the diverse nature of health requirements of the different states in India (Ruchismita, Ahmed & Rai, 2007).

In the partner-agent model, agents usually regard themselves as advocates of the insured rather than the insurer, though their financial incentive is aligned with that of the insurer. At the same time the insured feel that their money is lost to a distant company if not claimed at least once a year. Thus, the profit motive of the insurer might drive the premiums up (Rademacher, 2010). Mutual initiatives manage to overcome principal-agent problems in two ways: by designing a benefit package that aligns the interest of the insurer with that of the members; and by designing monitoring systems that involve the members in effective monitoring of the actions of the insurer (Dror, Perker, Jakab). However, none of the Models have actually shown an approach through which processes can be scaled.

McCord and Brown (2000) conclude that there is no single optimal health insurance model. The appropriate model depends on the availability of local healthcare services, the existence of insurance companies willing to service the poor, and the existence of institutions or associations to partner with or to serve as links between healthcare providers, insurers, and clients. Moreover, both models and all of the partners in the delivery should cooperate and prepare an overall performance picture of the HMI. It is likely that the agent in the Partner-Agent model would lead this endeavor, assuming that quality servicing of its customer base is of great importance (Garand and Wipf, 2010).

## Performance Measurement

Research of the performance of microinsurance programs is still in its infancy. However, conscious of the ongoing debate in microcredit circles, practitioners from microinsurance are keen to preempt the creation of lopsided sector, driven solely by questions of financial sustainability. The indicators in microinsurance, however, are promoted by the practitioners rather than by donors and investors as in microfinance (Sandmark & Simanowitz, 2011). With this in mind, the sector turned its gaze towards questions of financial sustainability first, much in the same way as MFIs were constrained into doing from the outset due to the finite nature of subsidies and donor support (Garand and Wipf, 2008). In this way, microinsurance providers had as a first concern how to manage their operations in as efficient and financially sustainable manner as possible, falling back on accurate tools for monitoring financial performance.

Efforts to make the social bottom line of microinsurance measurable have abounded, with an awareness that the client must be kept at the forefront of thinking in performance management. Following on from the financial performance indicators, the sector has also strived to establish consensus on how best to measure social performance. Over the years 2010-2011, many initiatives have been launched in international policy-making fora to promote issues linked to social performance. Organizations such as the ILO, the Microinsurance Network, and other affiliated organizations such as ADA and BRS have pushed ahead with tools to measure social performance and client value. In contrast to microfinance, however, where financial and social performance have been addressed in parallel, the aim in microinsurance has been to generate a cross-sector approach, with the same actors working on both dimensions of the bottom line (Sandmark and Simanowitz, 2011). However, the enthusiasm at the international level needs to be reflected by a stakeholder buy-in in the field, which in part explains why the tools proposed so far have sought to remain as simple and as least cumbersome as possible.

Although social performance should come naturally given the mission of microinsurance, there is a widespread feeling that it is management process that must be pursued in a deliberate and calculated fashion if it is indeed to have any impact. Microfinance has shown that selling credit to the poor is not in itself 'social', and can even have adverse effects on client lives. For this reason, social performance, and the management skills it entails, is in many ways a *sine qua non* condition for working towards the social bottom line. On the one hand, it can act as a check on the operational decisions governed by financial pressures. On the other, it can be pursued as a goal intended to realize the social dimension of the mission.

As explained in the previous section, measuring performance in microinsurance is complicated by the fact that there are often various partners involved in implementing a microinsurance scheme. This means having tools that can straddle the different functions of the partners involved in product delivery (Garand and Wipf, 2008). Furthermore, the discussed indicators are just key indicators and not the entire set of possible indicators. Each of them can be expanded into one or more sub-indicators which will provide in-depth understanding of organizational processes. Other indicators should be added if desired to measure operational areas that are not yet covered. However, those

should be added by the organization itself as they are organization specific and depend on the organizational mission and strategy.

## Financial Performance Indicators

The need to develop tools for financial performance management in microinsurance first emerged around 2005, with nine financial performance principles and ten key performance indicators, applicable to all models of microinsurance delivery and all types of insurance products, being agreed upon thereafter through a CGAP-hosted microinsurance working group (see Table 4).

Principles	Category	Financial Key Performance Indicators	Interpretation of Indicators
Separation of data	Product Value	Incurring expense ratio	The portion of premium required to cover all marketing, sales (including commissions), administration, claims settlement, and distribution costs.
Production of financial statements		Incurring claims ratio	Indicates the financial value of the insurance product to clients.
Collection of relevant and accurate data		Net income ratio	Measures program viability.
Calculating and setting up reserves	Product Awareness and Client Satisfaction	Renewal ratio	Are clients satisfied with the product?
Efficient and continuous claims monitoring		Coverage ratio	Shows what proportion of target population is covered.
Clear investment policy		Growth ratio	Growth reduces over time as the coverage ratio nears 100 percent. A fast growing scheme indicates positive social relevance to its target population.
Technical insurance capacity	Service Quality	Promptness of claims ratio	Are claims paid out in a timely manner to reduce cash-flow difficulties for clients? Are there too many obstacles for clients in claims submission?
Transparency		Claims rejection ratio	Hints at whether clients understand the insurance product, as well as whether the microinsurer is seeking to pay out claims.
Client focus	Financial Prudence	Solvency ratio	Indicates the financial strength of the insurance program and its ability to pay its obligations.
		Liquidity ratio	Too much liquidity increases costs or lowers benefits to clients because of lower investment returns. Insufficient liquidity delays claims payment and leads to bankruptcy.

Table 4: Key Financial Indicators; Source: Garand and Wipf, 2010

Participants from the CGAP forum (which has since become the Microinsurance Network) were aware that the sector should balance its financial exigencies with the social motives that underpin it. Thus, they created nine principles of financial monitoring where the principle of Client Value plays the role of aligning financial performance indicators with the social mission of the organizations. Viewing performance from that perspective is most meaningful for commercial businesses operating in a free market economy since in the end, good performance and greater efficiency boils down to delivering the best products and services in the most economical way to the consumer. In addition, the principles pertaining to data gathering and claims monitoring together with the incurred claims ratio indicator are particularly important for Health Microinsurance (Garand & Wipf, 2008).

The financial performance indicators are grouped in four categories: 1) Product value; 2) Product awareness and satisfaction; 3) Service quality; and 4) Financial prudence. These are also the four business processes of microinsurance according to Rademacher and Dror (2010). The categories are provided for the ease of digestion of the KPIs by practitioners and show the linkages between the different indicators. Those categories resemble the dimensions in the Balanced Scorecard which serve the same purpose of linking the effect of performance indicators throughout the organization and the program. Thus, this research undertakes to use the already developed KPIs and re-arrange them according to the Balanced Scorecard in order to provide even better overview of the effect of indicators to the organizational performance by not only linking them with each other but also with the organizational mission and strategy. This would guide the whole scheme towards alignment of strategy and operations which in the long run is expected to bring balance between client value and financial viability.

## **Financial Performance Measurement**

Angove and Tande (2011) investigate the commercial viability and profitability for five insurance companies through case study analysis based on three main drivers: 1) generating sufficient income by reaching scale measured by covered lives, premium volumes, and growth in premiums while considering appropriateness of premiums and client satisfaction; 2) managing claims costs is broken down to pricing for the risk, managing anti-selection, moral hazard and claims fraud, and managing claims volatility; and 3) acquisition and administration costs when working with partners, leveraging existing infrastructure, and efficiency in distribution and administration systems.

The Webinar on Viability organized by the ILO (November, 2011) expands on the above research and creates three crucial areas of financial performance management for commercial insurers: 1) growth of the microinsurance schemes including scale and outreach; 2) efficiency and profitability defined by profit, taxes, financial expenses, commercial expenses, advertising, management, and claims; and 3) viability. The case of interest that they discuss is the ICICI Lombard group-based health insurance – Manipal Arogya Suraksha (MAS). The growth of MAS is based on heavy state subsidizing which demands the commercial insurer to align business goals with the social mission of the government. Subsidies are needed in order to reach initial scale, which on the other hand, is crucial for the viability of HMI. According to Alok Agarwal, ICICI, the subsidies are used for building capacity. However, he admits that financial viability might also be achieved with fewer subsidies than the amount ICICI receives. Efficiency and profitability of the



scheme are determined by technology in the form of the development of smart ID Cards for customers and process efficiency when looking at client enrollment and claims.

In order for a scheme to be viable the combined ratio<sup>1</sup> should be below 100 percent. The key for financial viability of commercial insurers lies in achieving large enough scale. It is argued by the participants that sustainability can be reached in the long term as premiums are expected to increase with time due to customer education, awareness and high loyalty once they learn about the product. As scale increases with the initial help of state subsidies, the HMI schemes have time to develop necessary technology for Internal Business Process efficiency and managers will see decrease in process expenses which on the other hand brings along more resources for considering customer needs and increase in client value. This line of viewing the balance between financial and social performance relates to the maturity of the market.

At the same time Angove and Tande (2011) consider the different organizational structures as well as the importance of monitoring performance as a key to building a commercially viable microinsurance initiative. They recognize the social objectives of insurers but keep those out of the scope of their study. Their research, however, shows that microinsurance can be profitable in the long term.

## Social Performance Indicators

Social indicators focus primarily on the product and its purpose and on the relevant organization's mission. Therefore, to perform well the organization must have a clear social objective in its mission statement and business plan. Social performance indicators allow organizations to both monitor the achievement of these objectives and improve and enhance their operations. Additional benefits of integrating social performance indicators into the organization's operations include the demonstration of transparency, adherence to best practices and focus on clients' needs. As effective regulatory measures are not in place, social performance indicators can guide insurance regulators and be used in lobbying towards a more conducive regulatory framework including client protection (Sandmark & Simanowitz, 2011).

The first point of call for concrete measurement of social performance in microinsurance has been the creation of social performance principles and indicators (see Table 5). The indicators either point to issues that by their very nature are social, or flag issues of a financial nature that can have repercussions on social issues and client value. This explains why some of the indicators chosen to measure social performance are the same as some of the indicators used in appraising financial performance. Aside from making performance management simpler for the microinsurer, the overlap between social and financial performance indicators is also illustrative of the fact that both dimensions of

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<sup>1</sup> The combined ratio is comprised of the claims ratio and the expense ratio. A ratio below 100% indicates that the company is making underwriting profit while a ratio above 100% means that it is paying out more money in claims than it is receiving from premiums. Over a sustained period this could bankrupt a microinsurer. It can also point to adverse selection if the insurance product is voluntary.

the bottom line in microinsurance, at least as decided by microinsurers discussing performance management, are closer together than one might think. This helps provide a rebuttal for those that hide behind the trade-off excuse.

Category	Social Key Performance Indicators	Interpretation of Indicators
Product	Complaints ratio	Illustrates client dis/satisfaction and/or whether clients understand the product.
	Coverage ratio*	
	Renewal ratio*	
	Incurred claims ratio*	
Social Responsibility	Poverty outreach	Shows whether a microinsurer seeks to include those living below the poverty line.
	Social investment ratio	Underlines the extent to which a microinsurer pursues investments that are socially valuable to clients, even if no financial value is added.
	Rural outreach	Shows whether a microinsurer takes steps to include clients from rural areas.
Institutional Systems	Transparent sales ratio	Shows the degree of transparency in the marketing and sale of products to clients.
	Staff retention ratio	Hints at the HR practices of a microinsurer, but is also important with respect to front office familiarity with clients.
	Promptness of claims settlement*	
	Claims rejection ratio*	
Outcome/Impact	Out of pocket expenditure (OOPE)	After investment in the insurance, how much does the insured still need to pay.
	Claims incidence ratio	How many claims do you get compared to last year, implying that by investing in prevention activities, the number of claims event will go down

*Table 5: Social Performance Measurement of Microinsurance; Source: Sandmark and Simanowitz, 2010; \* Social and financial Indicators that overlap.*

The out of pocket expenditure ratio (OOPE) and claims incidence ratio have been presented during the Workshop as specific to Health Microinsurance and not the whole microinsurance industry.

The social indicators are also situated within four groups, resembling the financial indicators structure. Here, again the Balanced Scorecard is more useful than simple grouping as it links operational performance to strategic planning and keeps organizations on track with their social mission as they grow. Furthermore, the value of performance indicators lies in the degree of their institutionalization. Institutionalizing Social and Financial Performance Indicators requires organizations to have clear idea about their social performance objectives and the process to achieve those (IFAD, 2006). The BSC is a performance management tool that can provide the organizations with the skills to monitor systematically whether the strategic goals are operationalized correctly as to add value to clients in an efficient manner.

## Social Performance Measurement

Measuring social value is a much more difficult technical challenge than measuring financial return. It cannot be captured adequately in a single number or in five key indicators the way financial performance can be captured because social benefits take many forms and any decision to focus on one set of indicators will omit major portions of the total social return. Social value is not the same for each institution because goals and setting differ. While financial returns measure processes inside the financial institution, social returns occur outside the institution, not to the organization but to the clients. The external aspect of social returns means that the information used to determine social return needs to be collected separately which raises issues of cost and reliability. Finally social indicators are notoriously hard to measure (Rhyne, 2005) as they can be interpreted differently. For example, the poverty outreach is difficult to benchmark on as there is no consistent definition of “poor” (6th International Microinsurance Conference) and different organizations use different poverty scales which is also illustrated by the empirical data. Another example is rural outreach which is often not relevant as there are large numbers of uninsured in urban areas as well (6th International Microinsurance Conference).

Furthermore, there is the danger of social performance measurement being seen as a tax on microinsurance, holding back investments in the sector, or preventing young organizations from growing sufficiently. This might keep the sector away from benchmarking even though benchmarks are necessary for improving the performance results in the sector.

In 2011 the Microinsurance Innovation Facility introduced their client value assessment tool called PACE (Product, Access, Cost and Experience representing the four dimensions of the model). The tool is inspired by management models like the value disciplines (operational excellence, product leadership, and customer intimacy), marketing 4Ps, Six Sigma and the Balanced Scorecard. The PACE analysis needs to be used by management and be integrated into the strategic planning process. The underlying assumptions behind PACE is that products can deliver value only if they are: Appropriate: match the needs of the target population; Accessible: products are simple and delivered near the target group; Affordable: premium that the target population can pay; Responsive: prompt claims settlement and accurate answers to client queries; and foremost Simple: an overarching principle given the low literacy of the target population. The model is illustrated on Figure 7.

PACE incorporates a lot of the client value creation relevant KPIs. As KPIs signal the problem and help set priorities for improvement, PACE finds the reason for the issue. It can find value creation opportunities and explore strengths and weaknesses of current design.

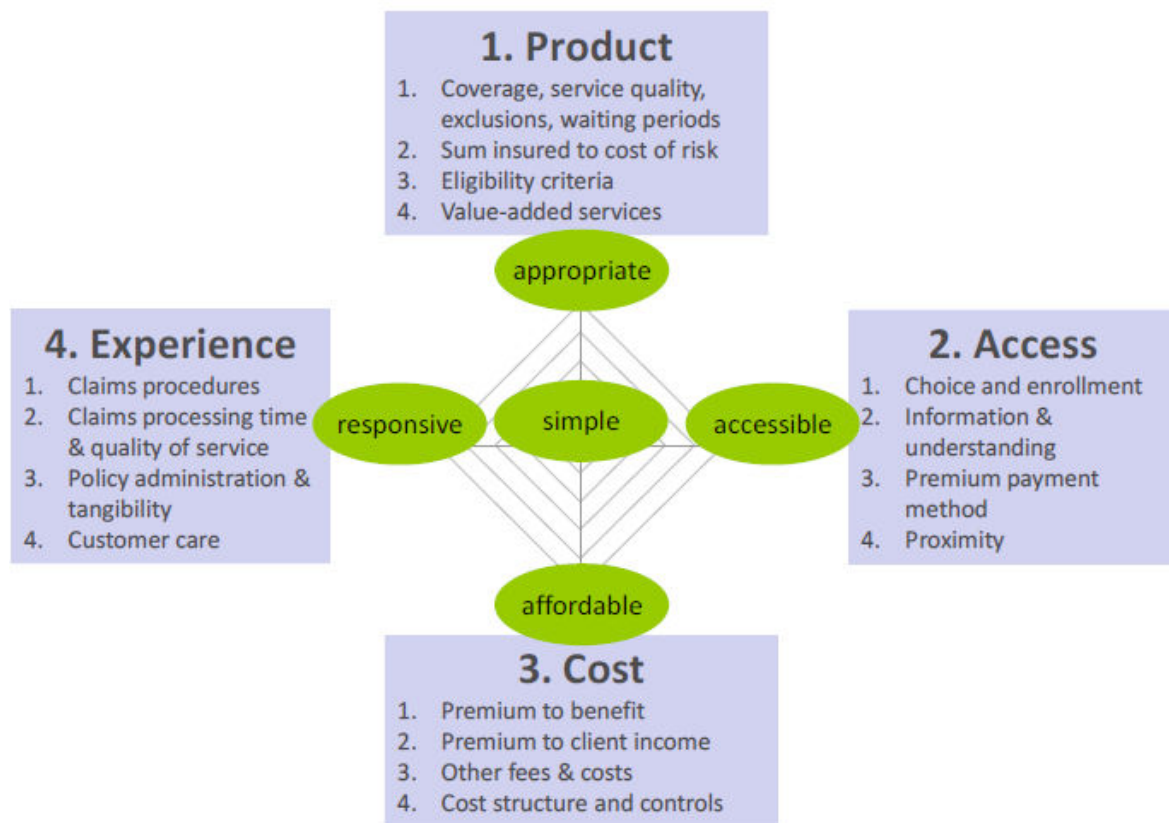


Figure 7: PACE client values assessment tool; Source: ILO Microinsurance Paper No. 12, 2011

There are intrinsic trade-offs between client value and business stability and therefore it is important to incorporate client considerations and feedback in strategic decisions, especially with growing competition. A “balanced” value approach across the four dimensions might not be the best choice for an insurer who wants to differentiate in a competitive market. However, client value improvements can be achieved through process efficiency gains rather than through an increase in premium. According to the model client value and business viability are interlinked: *“In microinsurance, like in any other retail business, client value should drive business viability.”* (ILO Paper No.12). However, given the lack of maturity and competitiveness in markets, a mandatory, low client value product can sell well and bring profits as clients might not have other options or might not be adequately educated. A good client value product can sell poorly due to low insurance literacy and make losses due to inadequate pricing, cost structure or lack of economies of scale. In the short term, business viability can be increased by reducing client value but this strategy is unlikely to work in the longer term, especially in a competitive market with educated consumers. In that line, subsidized products are not expected to perform sustainably in the long term as they would face high costs, low access, and average performance on experience and product (Webinar on Client Value). Thus, there is a correlation between client value and the maturity of markets.

The key data sources used in PACE are very similar to the ones for the BSC: product specifications, performance data, manuals and process flowcharts, reports and staff feedback, and primary data from clients. It can be done relatively quickly as it concentrates on the social performance of organizations only. PACE was applied on UpLift which is a case organization in this research. Therefore, the PACE findings will be incorporated in the analytical section of this paper.

The PACE tool should be included in the Balanced Scorecard model and should occupy the social performance part of the BSC which can be found in the Customer, Internal Business Processes, and Employee Learning dimensions. PACE helps managers step away from simply relying on flashy dashboards and institutionalize the results from the KPIs. Thus, this paper attempts to integrate both models.

## THE BALANCE BETWEEN FINANCIAL AND SOCIAL PERFORMANCE

This chapter reviews the literature on financial and social performance by combining the institutionalist and welfarist schools. The lack of the win-win perspective in the literature of performance is presented and the gap in balancing performance is closed by presenting the Balanced Scorecard as a holistic performance management tool that is appropriate to apply in the Health Microinsurance industry and should be considered by practitioners.

### Institutionalists vs. Welfarists

Microinsurance faces the same debate as microfinance, a debate on the assessment of the performance of the schemes that has emerged between the institutionalists and welfarists. Institutionalists believe that the performance should be assessed in terms of the institution's success in reaching a financially self-sustainable position. Welfarists believe that the performance should be assessed by determining whether the institution is successful in reaching its poverty alleviating objectives. Especially in policy circles there is a hefty debate on the compatibility versus the trade-off between sustainability and outreach. Whereas the welfarist view stresses the importance of outreach and the threat of focusing too much on sustainability, the institutionalist view claims that HMIs should focus on sustainability.

The institutionalist literature as discussed already includes Angove and Tande (2011) who investigate the financial viability and profitability of Health Microinsurance provided by commercial insurers. That is taken further by the Webinar on Viability discussions with representative from ICICI Lombard. Previous to that, is a discussion on the regulatory framework of microinsurance by Dennis Haensel (2010), where the need for regulation in order to encourage performance practices has been considered.

Further on, Rademacher, Singh & Srivastava (2010) discussed an integrated risk management perspective in microinsurance. They pointed at the lack of insurance specialist in the industry and tried to develop a risk matrix that could be considered when developing microinsurance products. Risk management skills are considered useful by the authors when it comes to financial sustainability. However, they ignore the social mission of the HMI industry.

Biener and Eling (2011) analyze data provided by the Performance Indicators Working Group of the Microinsurance Network using data envelopment analysis (DEA). This is the first article to analyze the efficiency of microinsurance programs. Another contribution is the transfer of frontier efficiency methodologies to the microinsurance industry and the incorporation of the social function (inadequate in health microinsurance) that microinsurers fulfill. According to their dataset, microinsurers that sell group policies are more efficient than those that sell individual policies. Growth strategies and merger activities are promising approaches toward an efficient production of insurance outputs; however, these strategies must be designed so that the pure technical efficiency of operations is achieved in the presence of increased size. Large microinsurers and for-profit microinsurers are best able to improve performance when focusing on the use of state-of-the-art technology, whereas concentrating on cost-minimizing input combinations is appropriate to address cost inefficiencies for small and for nonprofit microinsurers. However, these findings may not be representative of the entire health microinsurance industry. Thus, their empirical results indicate significant diversity and the potential for improvement in the microinsurance industry but it requires a more extensive

of the performance of health microinsurance programs. Their research shows the relevant insurance tools that can be applied when benchmarking microinsurance programs. However it is not applicable when looking at the small sample of health insurance schemes in India. Such a research requires a different set of tools.

The Welfarists camp is supported by the team behind the PACE tool and the Client Value Webinar, as well as the research provided by Yann Gelister on UpLift's social value. Despite, their work however, it is uncertain if the authors have not chosen the welfarist argumentation in order to initiate the provision of a balanced view of HMI performance as they were clear on the overlap of performance measures.

Vellakkal (2009) researched on the impact of the partner-agent model and found that given the existing incentive systems in the Indian insurance market for promoting microinsurance, the low level of insurance awareness among the clients and the dominant role of insurance agents results in (1) low level of health insurance coverage, (2) no adverse selection and (3) inequity in health insurance coverage. He defines the significant conditions for demand as the net-income maximizing behavior of insurance agents and the "insurance habit" of the customers. The last could be a reason for the health microinsurance schemes not always reaching the target beneficiaries. Opposing that, Bhat and Jain (2006) confirm that the knowledge and of health microinsurance in India plays an imperative role in the decision on the purchase of insurance products.

Little is known about the impact of HMI on health outcomes and household well-being, especially when it concerns the poorest individuals who tend to be excluded from HMI programs and who generally receive a lower quality of care (ILO, No. 6). Health outcomes remain an elusive target when measuring the impact of health system performance and the value of HMI. There are a number of factors that mitigate the ability to measure health outcomes, including but not limited to: poor data availability, the definition of meaningful measures across all populations, and the different abilities of academics and practitioners to conduct and analyze studies. While the research is fairly silent on this subject, the ability to define and measure health outcomes must become a routine operational competency (ILO, No. 6).

Alternatively, some are advocating the win-win proposition. At the heart of the debate, the question arises whether a trade-off between the financial sustainability and efficiency and the outreach to the poorest clients by insurance organizations exists. Devadasan et al (2004) discusses the access to health care for the insured. Utilization is in some cases significant and leads sometimes to serious financial challenges within the scheme but the additional costs related to the health care seeking process or way in which the reimbursement system is organized (bureaucracy, cashless, waiting period for reimbursement, etc.) also influences the access to health care for a significant degree. Moreover, a lot depends on the ideology of the organization that starts the scheme and the availability of external money to subsidize the premium or to provide health benefits that are not included in the benefit package offered by the formal insurance company. Devadasan & Nandraj (2006) suggest some indicators for monitoring the performance

of HMI schemes (see Annex II). They are not as exhaustive as the KPI list discussed earlier but incorporate both the social and financial side of performance

## The Balanced Scorecard

The Balanced Scorecard (BSC), as defined by Paul Niven (2003) is a carefully selected set of quantifiable measures derived from an organization's strategy. The basic premise behind the BSC is quite simple: measurement motivates. However, what eludes many is the easy path to identifying truly strategic measurements without falling back on things that are easier to measure (Sharma, 2009). The BSC considers the financial indices as well as the non-financial ones in determining the performance level; and it is not just a performance measurement tool, but also a performance management system that can be used in external reporting for an organization (Sharma, 2009). It is a formal management system that provides a realistic framework linking performance measurements to strategic objectives. The BSC approach addresses the issues of divergent stakeholder goals and gauging managers' effectiveness. It integrates the interests of the key stakeholders including owners, customers and employees (Kaplan & Norton, 1996).

The Balanced Scorecard was developed by Robert Kaplan and David Norton as a performance measurement framework that added strategic nonfinancial performance measures to traditional financial metrics to give managers and executives a more 'balanced' view of organizational performance. The Balanced Scorecard has the following functions according to Sharma (2009):

- Translates vision and strategy;
- Defines the strategic linkages to integrate performance across organizations;
- Communicates objectives and measures to a business unit, joint venture, or shared service;
- Aligns strategic initiatives;
- Aligns everyone within an organization so that all employees understand how and what they do supports the strategy;
- Provides feedback to the senior management if the strategy is working.

The scorecard lets management introduce four new processes that contribute to linking long-term strategic objectives with short-term actions: 1) *translating the vision* – helps managers build a consensus around the organization's vision and strategy; 2) *communicating and linking* – lets managers communicate their strategy up and down the organization and link it to departmental and individual objectives; 3) *business planning* – enables companies to integrate their business and financial plans. When managers use the ambitious goals set for BSC measures as the basis for allocating resources and setting priorities, they can undertake and coordinate only those initiatives that move them toward their long-term strategic objectives; 4) *feedback and learning* – gives companies the capacity for strategic learning. (Kaplan & Norton, 2007)

The term 'balance' reflects the attempt to capture both financial and non-financial measurements with emphasis on lagging and leading indicators, long-term strategic objectives and short-term actions, external and internal



performance perspectives, as well as quantitative-objective and qualitative-subjective measures (Kaplan & Norton, 1996; Niven 2003). It provides a system for balancing social and financial performance.

### **BSC Perspectives:**

Kaplan and Norton (1992) proposed four balanced perspectives to measure performance comprehensively including financial, customer, internal business processes, and learning and growth perspective. These perspectives reflect the interests of the key stakeholders of companies involving shareholders, customers and employees and serve as a structure within which to develop metrics, collect and analyze data.

#### **Customer Perspective**

Performance measurements from the customer perspective indicate the company's sources of demand. This perspective forces the company to view its performance through the customers' eyes (Kaplan & Norton, 1992). The emphasis on customers should take care of satisfaction, loyalty, retention and acquisition of customers (Kaplan & Norton, 1996). This perspective should also measure the *value proposition*—how the organization creates value for its targeted customers (Kaplan, 2001). These are leading indicators—if customers are not satisfied, they will eventually find other suppliers that will meet their needs. Poor performance from this perspective is thus a leading indicator of future decline, even if the current financial picture looks good. In developing metrics for satisfaction, customers should be analyzed in terms of kinds of customers and the kinds of processes for which a product or service to those customer groups is provided (Sharma, 2009).

#### **Financial Perspective**

Performance measurements from the financial perspective indicate *"whether the company's strategy, implementation, and execution are contribution to bottom-line improvement"* (Kaplan & Norton, 1992, p.77). Kaplan and Norton do not disregard the traditional need for financial data. Timely and accurate funding data will always be a priority with managers doing everything necessary to provide it. However, the point is that, the emphasis on financial only leads to the 'unbalanced' situation with regard to other perspectives (Sharma, 2009).

#### **Business Process Perspective**

Mooraj et al. (1999) argued that the internal business process perspective of BSC focused on the internal processes required for excelling in efficiently providing the value expected by customers. To satisfy customer needs and to achieve better competitive advantage, many firms have concentrated their efforts on the improvement of internal business processes. Metrics based on this perspective allow the managers to know how well their business is running and whether its products and services conform to customer requirements (the mission). The internal process perspective includes measures of operating performance (cost, quality, and cycle times) of critical processes that deliver value to customers and reduce operating expenses. In addition, the internal perspective can include measures of innovation processes that create entirely new products and services (Kaplan, 2001). These metrics have to be carefully designed by those who know these processes most intimately (Sharma, 2009).

### *Learning and Growth Perspective*

Kaplan and Norton emphasize that 'learning' is more than 'training'; it also includes things like mentors and tutors within the organization, as well as that ease of communication among workers that allows them to readily get help on a problem when it is needed (Sharma, 2009). Investments in microinsurance have diverse returns that evolve over time: reputational gains in the short term, knowledge in the medium term and growth in the long term. Organizational learning and growth arise from such sources as people and systems. If insurance is a sector in which knowledge is a decisive resource, then microinsurance can be viewed as a driver of local learning and ultimately economic growth (LLOYD'S). Typical measures for the learning and growth perspective include employee motivation, retention, capabilities, and alignment, as well as information system capabilities (Kaplan, 2001). In terms of the learning and growth perspective, Kaplan and Norton (1992) stated that the firm's ability to innovate, improve and learn could tie in to the firm's value.

The Balanced Scorecard model applicable to the Health Microinsurance industry is borrowed by Paul Niven and presented on Figure 8. Even though, Health Microinsurance includes both profit and non-profit organizations, the model is found appropriate because of the importance given to the mission of the organization. Healthcare is a social / public sector issue and despite the market orientation of microinsurance, the ultimate goal is access to better health opportunities and lifting health-related financial burden from the poor people. Here, the Customer perspective is elevated, followed by financial and business processes perspective. Financial considerations can play an enabling or constraining role but will rarely be the primary objective (Kaplan, 2001). This is also the case of healthcare and microinsurance where the organization depends on the trust of customers. However, without financial resources the organization will not exist and, thus, the need for a finance perspective. Paul Niven (2009) suggests that organizations must move away from their reliance on financial measures and build new frameworks by implementing a performance measurement system to help them execute their strategies: *"Not only will the process force you to determine what your outcomes will be, but it will also help you better allocate your resources."*

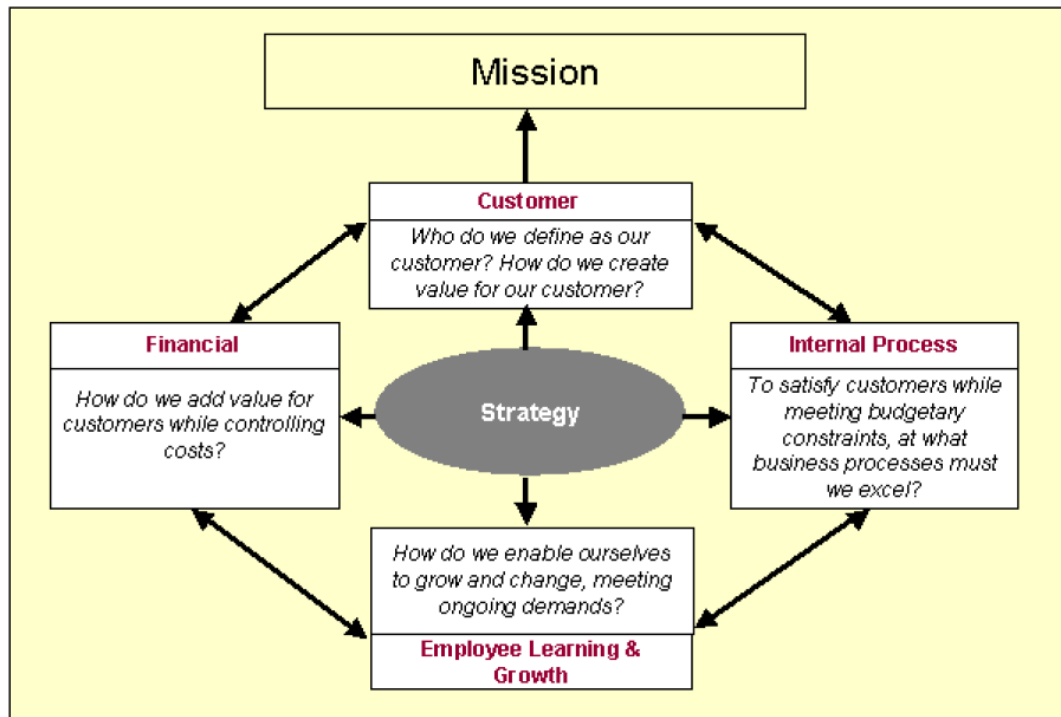


Figure 8: BSC for Nonprofits by Paul Niven

Kaplan and Norton (1996) proposed the cause-and-effect relationships among the four perspectives of BSC by measuring the strength of the linkages among measures in different perspectives. Accordingly, the interrelationships among different perspectives of BSC favor selection of appropriate measurements for the company and enhancement of advantage of the performance measurement system. For instance, a degree of improvement of internal business process and level of customer satisfaction will in turn affect the financial perspective. Within each of these perspectives management should identify performance measures and metrics that have a strong cause-and-effect relationship that clearly defines the organizational strategy. The importance of cause and effect: relates indicators / measures to strategy and vice versa. The linkage of measures is constructed based on assumptions. A well-constructed BSC should describe how the organization works, and what is critical to its success, through a series of interconnected objectives and measures running through the four perspectives, rather than focusing exclusively on any one element. Each element represents a vital link in the cause-and-effect relationships that run through the BSC. It is only by linking all performance measures in a coherent whole that the strategy can be analyzed (Niven, 2003).

### Mission and Strategy

The mission cannot be achieved overnight and therefore the four perspectives provide with important short to medium-term information that is required to guide organizations in achieving their mission in the long run. The mission statement needs to be simple and clear, long term in nature, to inspire change, and easy to understand and communicate. However, it is only through measurement that any real difference in the lives of the constituents can be claimed (Niven, 2003). The mission needs to be consistent with the values and vision of the organization and any mission drifts can be detected through the Balanced Scorecard framework.

Strategy is central and in fact the driving force behind the BSC. Generally speaking, goals relate to outcomes and strategies relate to procedures. Measures can and should relate to both. Process (lead) measures can be used to reflect how well the organization is executing its strategies. Outcome (lag) measures can be used to indicate how well the strategies actually accomplish their intended results (Zimmerman, 2004). Besides that, *“strategy is not only what the organization intends to do, but also what it decides not to do, a message that is particularly relevant for nonprofits”* (Kaplan, 2001; p. 358). The start of any performance measurement system has to be a clear strategy statement. Otherwise, performance measures focus on local operational improvements rather than on whether the strategy is being achieved. By quantifying and measuring the strategy, organizations reduce and even eliminate ambiguity and confusion about objectives and methods. They gain coherence and focus in pursuit of their mission.

### ***Key Performance Indicators (KPIs)***

Performance measures may be considered standards used to evaluate and communicate performance against expected results. Not only do measures provide managers and executives with a tool to gauge organizational progress, but, when well crafted, they can inspire and motivate all employees, set direction for the organization, and encourage alignment from top to bottom (Nivel, 2003). Indicators act as markers to help show if and how changes are happening over a period of time and allow for the establishment of benchmarks against which to judge whether objectives are being met (IFAD, 2006). The measures should be naturally related to the key drivers of performance (Kocakulah & Austill, 2007).

The recommended number of indicators by Kaplan and Norton are 20-25 measures altogether (5 indicators per perspective). It is impossible to monitor every aspect of performance, so it is important to choose a small number of indicators that will produce the most important information needed. There are several types of performance measures that should be considered when designing a Balanced Scorecard (Niven, 2003; social performance framework in microfinance; Ramias & Wilkins, 2010):

- Input measures: Learning and growth and Financials
- Output measures: Internal business processes
- Outcome measures: reflected in the mission ( number of healthy clients) and in the customer perspective (customer satisfaction)
- Lag & lead indicators: results at the end of a period (financials) & measure intermediate processes and activities that lead to the performance of lag measures

Managers should not just monitor indicators regularly but also make sure that these indicators read trends rather than “spot” data. It is also crucial to research what is behind those indicating numbers through tools like PACE.

When combining the BSC framework with the social and financial performance measurement literature it becomes clear that financial measures are found in the Financial and some in the Internal Process perspectives while social performance is measured by the Customer, Internal Process and Employee Learning & Growth perspectives.

The desired result of a performance measure is represented by targets that inform the whole organization of the expected level of performance required to achieve success. They typically drive a focus on continuous improvement as the organization strives to constantly better its performance (Niven, 2003) by lowering the gap between the target and the actual result. The HMI targets are set at industry level according to available statistics used for comparison purposes. The gap can be closed by realizing the organization's Critical Success Factors (CSFs) (Roger Burlton, 2010). CSFs can be discovered through process mapping. Process mapping can be used once the weak performance indicators are unveiled. Process mapping relates to operations efficiency as it illustrates the development of input into output. It helps find the shortest way to achieving a strategic goal (see Process mapping in microinsurance, Steinmann 2011, JIFAD).

Zimmerman (2004) suggests the following implementation steps of the BSC:

1. Get your Board of Directors and managers educated on the basics and committed to the effort.
2. Appoint someone on staff to be in charge of creating and maintaining the balanced scorecard.
  1. Depending on your organization's size, and the knowledge of the person you have placed in charge, you may need to hire a consultant to assist in this effort.
2. Build your scorecard categories to match what is in your strategic plan. Or, build your strategic plan around the categories you will use for the scorecard. Or, modify your existing strategic plan so its matches the scorecard categories.
3. Derive the balanced scorecard measures, metrics, and analytical techniques and implement them in test mode for two or three months.
4. Use the test experience to improve the balanced scorecard measures and processes.
5. Begin to collect, analyze, report, and archive scorecard measures on a regular (e.g., monthly or quarterly) basis. This implies the use of tools like the Microinsurance Factsheet. However, performance management is not limited to gathering data on measures in a consistent matter.

While the technique described in professional literature accumulates the wisdom and experience of many people and represents a form of best practice, it should not be copied blindly under the assumption that one size fits all. In particular, the four major dimensions (financial, customer, internal, and innovation and learning) should be further modified to fit an organization (Zimmerman, 2004). Furthermore, Sharma (2009) points at the fact that it is not easy to implement this tool because it involves a lot of subjectivity. Also, BSC is much more complex compared to other performance measurement tools. The measures are contingent upon the kind of environment, industry and the business the organization is in. Although BSC has been adopted widely by different industries, there is no formal

implementation methodology. This lack of formal implemented methodology and subjective measures often leads to focusing on short-term financial measures.

The tool has tried to fill up the void that exists in most management systems—that is the lack of a systematic process to implement and obtain feedback about the organization's strategy. However, a lot of refinement is still required, so that it becomes understandable to every stakeholder associated with the organization and removing subjectivity to a large extent (Sharma, 2009). While it does, in theory and over time, lead an organization to more efficient and effective practices, the balanced scorecard requires an organization to invest substantial time, energy, and talent upfront to make it work well (Zimmerman, 2004). Another limitation of the BSC is that it is a top-down approach only. Therefore, the interactions between top management team and working level employees are limited. Also, researchers seem not to reach a consistent agreement on the interrelationship between the four perspectives of the BSC (Chiang and Lin, 2009).

Finally, according to Fletcher and Smith (2004), the BSC lacks a single focus for accountability. What the BSC does not do but what managers need is one comprehensive index to summarize the interaction between these leading and lagging measures of performance. While the BSC may tell what measures to look at, it does not tell how to look at them or their relative importance thus it makes a poor tool for benchmarking. DEA can analyze multiple inputs and outputs simultaneously, as well as show by what percentage the inputs should decrease in order to achieve a given output level and by what percentage the outputs should increase given original levels of inputs in order to reach efficiency. Hence, DEA can transform performance measures into managerial information. On the other hand, BSC can provide appropriate outputs for DEA (see ANNEX III). Accordingly, the synergy of BSC and DEA can translate the appropriate performance indices into managerial implications. BSC and DEA are different concepts but complementary to each other (Chiang & Lin, 2009).

Although BSC has some limitations it can also benefit Health Microinsurers, regardless of their status as profit or non-profit (Kocakulah & Austil, 2007; Sharma, 2009; Paul Niven, 2003):

- A BSC provides a snapshot of the organizational performance that is easy to understand, and it can enhance communication with key stakeholder groups from consumers to employees
- A BSC allows the organization to have an early warning system before the organization begins to feel the harsh impact on operating
- For nonprofit, the BSC is adaptable and fits the complexity of social missions and avoids overemphasis on financial measures as the organizations respond to increasing demands for quality and satisfaction
- The BSC development process forces the organization to clarify and gain consensus on the strategy.
- The four perspectives of the BCS give executives a framework for decision making.
- The BSC sets priorities by identifying, rationalizing, and aligning initiatives. The executives can then focus their attention, and front line workers can then understand the value of their work and how it relates to the organization's strategic objectives.

- The BSC links strategy with resource allocation.
- The BSC supports greater accountability.
- The BSC enables learning and continuous improvement. It speeds up the pace of learning because the actual results are compared to an industry target.
- BSCs can add customer/client insights and feedback to enhance marketing.
- The organization can refocus internal operations and can revise strategies as necessary.
- The process can energize internal stakeholders of the organization.
- BSCs can strengthen customer acquisition efforts.
- Because more attention is paid to the customer, the relationship with the customer will be strengthened.
- BSC use can increase customer and employee loyalty and return of value
- BSC can help attract scarce resources (Funding & Employees)
- BSC produces information, not data

The balanced scorecard is therefore a very important strategic management tool which helps an organization not only to measure performance, but also decide/manage the strategies needed to be adopted/modified so that the long-term goals are achieved. In other words, the application of this tool ensures the consistency of vision and action which is the first step towards the development of a sustainable organization.

## METHODOLOGY

This chapter describes the research approach, strategy, the credibility of the research findings, the research method, and the research model and hypothesis. The research approach illustrates how theory is used in understanding and answering the problem statement through the respective sub-research questions, and the research strategy explains how empirical data is gathered and analyzed. The research is structured in scope by a number of delimitations that are elaborated on in the subsequent section. Then various criteria surrounding reliability and validity within business research are described and discussed (Bryman and Bell, 2003). The research method that explains the process of conducting the study is presented. Finally, the assumptions and hypothesis that structure the research are revealed. The chapter ends with translating the research problem into the model of the paper.

### Research Approach

The research is performed in order to answer the problem statement and the subsequent research questions, which emerge from the gap between theory and practice. To ensure a comprehensive analysis and valid conclusions, the type of the research setting of the paper and the research methods are dictated by the research focus (Eriksson & Kovalainen, 2008). The research is conducted following the positivist epistemological tradition, while the stand point of the researcher is rooted in objectivist ontology as the organizations are analyzed from an external angle. Thus, the research is positioned in the functionalist paradigm where a problem-solving orientation leads to the rational explanation of events (Saunders, 2007; Bryman and Bell, 2003).

To that end, a deductive reasoning is employed in order to construct and understand the performance measurement and management practices in the field of Health Microinsurance in India. The research approach determines how and what empirical data should be collected and analyzed. The deductive research approach represents the most common view to consider the relationship between theory and research. The approach has its foundation in theory, which is used as the point of departure for the collection of empirical data and drives the further analysis

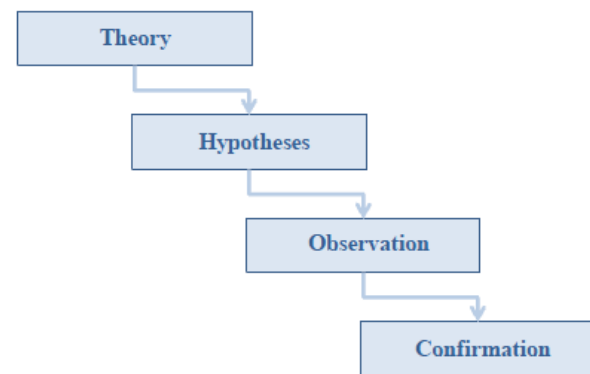


Figure 9: The research approach; Source: Bryman & Bell, 2003

of the material (Bryman & Bell, 2003). Deductive reasoning attempts to demonstrate that a conclusion necessarily follows from a set of premises or hypotheses. The deductive logic allows deriving „b“ from „a“ only when „b“ is a formal consequence of „a“, i.e. the process of deduction leads to deriving the consequences of what is assumed. It follows from the general to the specific. In this research deductive reasoning is used to build hypothesis for whether and how the delivery model of Health Microinsurance influences the performance measurement practices of such schemes. It is further on used to analyze the existence of trade-off between social and financial performance in HMI and the effect of the delivery model on a balanced performance relationship. To identify the relations between the different models and the performance measurement, I use already existing literature from institutionalist and



welfarist line of thought as well as the Balanced Scorecard model, as the most appropriate framework for analyzing the balance of organizational performance in the long term. The hypotheses are then tested with the empirical data from five different Health Microinsurance schemes. Those hypotheses are dimensions on which I compare the performance measurement practices of the existing delivery models. The novelty of this research comes not from the research approach but from the choice of theoretical model and its application in a new industry. Thus, the model is modified through the application of empirical observations as the need for better performance practices, i.e. the adaptation of the model in HMI, is confirmed (see Figure 9).

## Research Strategy

The paper's research strategy is constructed towards a multiple-case study design with qualitative methods as the primary technique. Qualitative research approaches are traditionally used for creating theoretical ideas which emerge from empirical data. However, qualitative methods can also be used to test and revise theories (Bryman & Bell, 2003). A case study strategy is particularly relevant when dealing with „how“, „what“ and “why” questions in explanatory research (Saunders, 2007). This explanatory study aims to understand the relationship between variables revealed by theoretical models. This research strategy enables and encourages method triangulation which adds credibility to the research. Moreover, the case study and qualitative methods strategy minimizes the influence of subjectivity. Another benefit of utilizing the case study method is the flexibility in selecting the cases that makes it possible to maximize what can be learned throughout the research (Saunders, 2007). Case study research is particularly useful when complex social phenomena need to be understood (Yin, 2009; Saunders, 2007). Thus, the focus of the research is on contemporary events with a real life context (Yin, 2009).

The multiple-case design used here is often considered as quite compelling design that ensures that the overall result would be more robust (Yin, 2009). The case study design of this thesis is also classified as an embedded case study design, which denotes that there are multiple units of analysis, namely resources and capabilities, networks, organizational design, business model and others.

The cases are selected based on the amount of data available, the quality of the data and the data's ability to shed light on the research questions. The cases within the case study design share some common characteristics which makes them more comparable in the analysis section (Yin, 2009). All cases are organizations offering Health Microinsurance in India at the same delivery level but of different models in order to create a more holistic framework of HMI performance needs.

The case study research has some downsides as well. It is likely to encounter methodological issues, such as personal bias from participants and subjects. However, this is not the situation when the case study also relies on existing material, documentation or other one-way information streams. The information provided by the companies has been cross checked with information provided by specialists and enablers in the industry. The analysis of the cases in this paper, as well as the construction of the business models and performance practices are constructed from both

existing materials such as industry reports by reliable agencies and consulting companies, formal studies, news clipping and articles, and case study material and industry knowledge gathered through interviews which provide more insightful information (Yin, 2009). The cases included in this research are presented in more detail in the next section.

A main weakness of the present study is the lack of strong evidence regarding performance measures and practices of most of the selected organizations; hence there is limited information of relevance to the current study in written secondary sources. To tackle this deficiency, data has been collected via interviews with industry experts, enablers and managers. They have provided generalized data in the form of statements.

### **Level and Unit of Analysis**

The level of analysis of this thesis is the performance measurement and management activities of the Health Microinsurance schemes in India and how these activities are affected by the different strategies of organizations with different delivery models. The unit of analysis is the Health Microinsurance organization that is organizing and managing the microinsurance product. Each unit is first analyzed individually and then analyzed according to the delivery model it belongs to. That ensures the consideration of all variables at play.

### **Delimitations and Scope of the Thesis**

A number of delimitations have been decided upon in order to focus the research topic. Firstly, the research investigates only Health Microinsurance organizations as health microinsurance is considered to be of primary importance to poor people. It requires more attention from academic researchers due to the high demand and technical complexity of the product. Therefore, the research does not include other types of microinsurance even though some organizations offer a financial service package of which HMI is only a small fraction and clearly, the variables in the microinsurance portfolio need to be explored in relations to client value and sustainability.

Secondly, the research includes only two delivery models for performance benchmarking. The Mutual and Partner-Agent model are considered to be the two common models of HMI delivery in India. The HMI organizations from both models were chosen due to similar responsibilities when it comes to performance management in the delivery chain. However, the amount and variety of organizations in HMI is quite broad. National schemes organized by the government, provider-based schemes, informal ways of insurance, as well as cooperatives should also be considered in relations to benchmarking performance. This is not the case in the present research as performance measurement is a rising practice and many of the mentioned organizations do not possess data which can be used for benchmarking. Further research should consider looking at different cases as well as field work in order to help organizations collect necessary data.

Thirdly, this research is only on India. Besides that, there are only certain states of India that have been considered. However, the target population amongst organization varies immensely. Nevertheless, more research should be conducted on different parts of India and populations with different poverty levels in order for the findings to be even

country generalizable. At present, the data collected is case specific and can be used as inspiration but should not be transferred directly to other organizations in India or the rest of the developing world.

Fourthly, this analysis is on performance practices and the relevant organizational strategy and mission only. There is a variety of problems in health microinsurance - from need and design to health related outcomes of quality and impact on clients. Such topics are given different amount of attention in the existing literature as design and delivery models are highly discussed, outcome has hardly been touched upon due to its timely and costly procedures of analyzing. This research, however, is based on day-to-day activity and operations according to already existing strategic goals. There is recognized need for a lot more research done in Health Microinsurance.

Fifth, the starting point of this research is on the internal management perspective of HMI organizations. Even though a holistic framework has been provided it is mostly considered for internal use. The Balanced Scorecard model considers stakeholder influence and the role of investors and community has been shortly mentioned. However, the topic needs further external elaborations as the importance of indicators and their scale measurement might have different importance to the different stakeholders.

Also, the research is relying on the welafrist and institutionalist perspectives to analyze a balanced performance. It also uses the BSC tool from the social and financial performance perspective. This is considered as a good introduction to the development of a holistic performance management tool. However, such framework is not extensive enough as to provide in-depth guidelines for appropriate utilization of such framework. Furthermore, the focus on industry key performance indicators is not sufficient for the development of a performance management system. This can only be done by breaking the KPIs into organizational specific processes and defining organizational specific measures that can be institutionalized. Additionally, the literature on performance could use a more in-depth theoretical background.

## **Validity and Reliability**

The following section comments on how a number of criteria for sound business research are addressed. In general, reliability and validity, commonly referred to as traditional research criteria, stand for whether the results of a study are repeatable, and whether the integrity of the results is intact (Bryman and Bell, 2003). However, the concepts were originally developed and applied to quantitative research which is their major deficiency when applied to qualitative studies such as the current one.

Based on the concept of validity and reliability, „trustworthiness“ of research was developed as a better criterion for qualitative research (Bryman and Bell, 2003). Trustworthiness is comprised of four criteria for judging the soundness of qualitative research as an alternative to the traditional quantitatively-oriented criteria. Table 6 presents the criteria.

Criteria	Explanation	Strategy to Enhance the Criteria
credibility	establishing that the results of qualitative research are credible or believable from the perspective of the participant in the research	participants are the only ones who could confirm the credibility of the results
transferability	the degree to which the results of qualitative research can be generalized or transferred to other contexts or settings	by describing the research context and the assumptions that were central to the research
dependability	whether the same results would be obtained if the phenomenon is observed twice	to measure the same phenomenon twice; as this is impossible in practice the researcher should describe the changes that occur in the setting and how these changes affected the way the research approached the study
confirmability	the degree to which the results could be confirmed or corroborated by others	among others, the researcher can document the procedures for checking and rechecking the data throughout the study

*Table 6: Criteria for Validity and Reliability of a qualitative research; Source: Bryman and Bell (2003); socialresearchmethods.net, accessed on 04.05.2011*

To ensure that the research maintains trustworthiness and accomplishes its goals, below is a discussion of the four dimensions as applicable to the current study. To increase the credibility of the paper, the research findings are confirmed and discussed with the people who participated in the study. Moreover, data triangulation is used as a means to improve the credibility – by combining multiple sources; evidence has been cross-checked.

The goal of the paper is to revise and enhance the BSC as a performance measurement tool that can be useful to practitioners in HMI. However, the conclusions are not applicable to all types of HMI schemes due to the chosen delimitations. The outcome of the analysis is applicable to organizations that share common characteristics with those in this research paper and are in similar business and legal environment. Ultimately the findings can be used as inspiration by other organizations. Dependability and confirmability are ensured through a detailed account and consideration of the settings within which this research has been conducted. Explanation of the procedures for checking data, argumentation and conclusions are also available.

## Research Method

The process started with the identification of a broad topic of interest. As an outcome of an initial literature review and a preliminary discussion with industry experts, the topic was narrowed down to an interesting and current problem that is faced in practice in the industry and that also relates to lack of academic interest and literature.

The first set of interviews was held with industry experts. The sole purpose of those interviews in the explorative phase was to gain a broad perspective of the industry in general for the further literature process. The, following set of interviews that is presented in this paper was conducted in a semi-structured way – a method that supports an open discussion of larger amount of issues. Following such an explorative approach helped the author to uncover industry specific issues.

The research focus was further scoped and refined with the conduction of a subsequent in-depth focused literature review. Conducting such a literature review allowed for (1) the identification of the theoretical themes that would support the structure and argumentation, (2) the development of the logical flow and structure of the study, as well as (3) the identification of the data that was needed for the proper analysis of the problem statement. The literature review was earlier presented along the lines of the theoretical discussion on trade-off between outreach and value-adding benefits and efficiency and financial viability. Furthermore, the literature on financial and social indicators existing in the sector so far is also included.

The primary data for this study has been collected in the form of five interviews. Interviewees have been classified as industry experts, managers and CEOs, and those have been selected based on their knowledge and experience in the research field as well as on the sampling technique used for the case study strategy of the study. An overview of the interviews is available in Annex IV. Most of the empirical data is gathered through those interviews, although this methodology is not without its challenges. Some of the interviewees were reluctant to share internal sensitive information regarding strategies, processes, core knowledge and competencies. Therefore, such research methodologies relying on collecting divulging data are likely to suffer from a high non-response bias and criticism regarding the transferability of such a small sample research. Such challenges are also applicable to the research primary data collection as some of the interviews could not be recorded because of language skill impediments and lack of time or interest in participating. Therefore, the five interviews are followed by two interviews through e-mail that can also be seen in Annex IV. The data collection is further challenged by the lack of full set of information on Health Microinsurance as the industry is still learning by doing and the practitioners themselves do not have much historical data. However, the data collected through primary research is considered sufficient for simply initiating a holistic research of performance in the industry as this is the first research of this kind.

Saunders et al (2007) explain that using a case study strategy often requires a sampling technique in order to reduce the amount of data, because of the impossibility of collecting data from the entire population. Hence sampling technique is the right method for collecting data in the case of the current study. This is, however, a different kind of sampling that the one used in statistical analysis. Sampling here is understood through replicating a number of similar cases (Eriksson, 2008). As per above, the initial data collection phase covered industry experts and was of general nature. The next stage of data collection covered company managers and CEOs. The aim of those interviews was to obtain a deeper understanding of the interviewees' perception of the research field and to gain company-specific data. Finally, the last interview with the Head of the Microinsurance Performance Working Group was conducted with a goal to confirm the findings of the study and to clarify some missing data. All semi-structured interviews consisted of pre-prepared questions based upon the theoretical framework and were presented to the interviewees in an interview guide. The interview themes in the guide were conducted according to the existing literature and theoretical tools that can identify and test relationships between performance related variables (Saunders, 2007). Even though the interview topics are the same the questions were adapted to the knowledge-base of the interviewee.

That data is of general nature and the company-specific empirical evidence is analyzed in the form of common patterns, i.e. the two delivery models. Although data that has been gathered in that way and form cannot be considered as strong evidence, it is considered reliable enough so as to be used for the testing of hypothesis and the subsequent analysis and discussion.

Secondary data includes industry reports by reliable agencies and consulting companies, formal studies, news clipping and articles, case study materials, on-line interviews with specialist and practitioners and Webinars conducted by research organizations. At the organization level the data consists of mission statement, values, vision, strategic plan, annual plans, mandates, organizational history, costumer surveys as recommended for data collection by Paul Niven (2003) and the PACE framework. A list of the secondary sources is available in ANNEX V.

The information from both primary and secondary sources is often complex, rich in details, and delivered in a non-standardized way. Therefore data from the case companies (including information from company CEO and managers) had to be classified into categories before it could be meaningfully analyzed. Thus, data was analyzed using explanation - building data analysis through hypothesis testing. This includes an iterative search process for causal links in the empirical data through content analysis, which are then presented in narrative form (Yin,2003; Saunders, 2007).

## Hypothesis and the Research Model

The existing literature, the PACE tool and the BSC model serve as a basis to the assumptions of the following case analysis. According to those assumptions four hypotheses are presented below.

Firstly, the research concentrates on the financial performance of Health Microinsurance organizations. The general assumption underlying Hypothesis 1 is that the social mission of organizations implies lower financial performance.

### ***H1: The type of delivery model has an impact on financial performance***

The stronger the social orientation of organizations, the less attention will be paid to purely financial performance measures. Based on the literature so far, it is clear that mainly commercial insurers have participated in financial performance research. The expectation is that Mutual microinsurers are responsible to the community that manages them and so they are only interested in financial performance in relation to satisfying the community. At the same time for-profit insurers pay most attention on indicators like net income, incurred expense and solvency. Thus, the difference in financial performance measurement practices between the two models due to differences in their mission and strategy.

Secondly, the research concentrates on the social performance in HMI. The general assumption underlying Hypothesis 2 is that the stronger social ideology of the organization implies higher interest in social performance measurement.

***H2: The type of delivery model has an impact on social performance***

A lot depends on the ideology of the organization that starts the scheme and also on the availability of external money to subsidize the premium or to provide health benefits that are not included in the benefit package offered by formal insurance companies. Mutual organizations, that have been active participants in client value research, are often started by the community they serve and are as such expected to follow on the healthcare development in that community. More so, as the Partner-Agent model is more market based, the social value offered at the start is expected to be of less importance than the sustainability of the scheme. However, government subsidizing of commercial insurers is expected to have an effect on the strategic goals of those organizations. Therefore, the between model differences are yet to be determined.

Thirdly, the research explores the occurrence trade-off between social performance and financial performance.

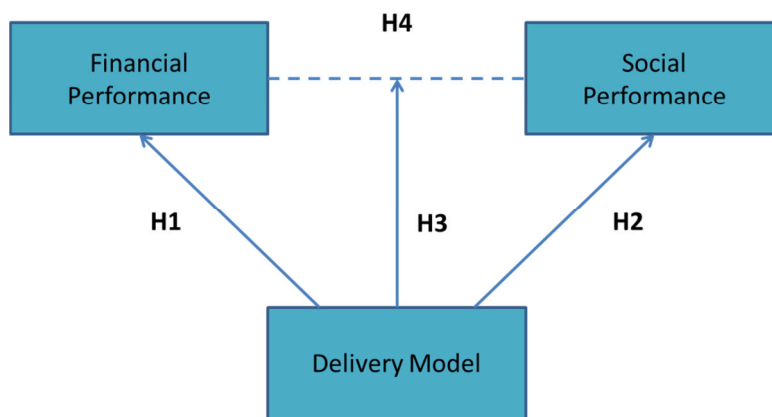
***H3: A negative relationship is found between financial and social performance***

Based on the available literature from both microinsurance and microfinance there is an observed trade-off between outreach and efficiency. Therefore, it is interesting to see whether Health Microinsurance is also falling under the threat of mission drift that has created very serious challenges to the model of microfinance during the last few years. Given the lack of maturity and competitiveness in microinsurance markets, a mandatory, low client value product can sell well and bring profits as clients might not have other options or might not be adequately educated. A good client value product can sell poorly due to low insurance literacy and make losses due to inadequate pricing, cost structure or lack of economies of scale. In the short term, business viability can be increased by reducing client value but this strategy is unlikely to work in the longer term, especially in a competitive market with educated consumers. Such finding will strengthen the need for performance measurement by HMI organization in order for them to be able to attract funds. It will furthermore, answer the main research question of this study on the balance in social and financial performance in Health Microinsurance.

Fourth, Hypothesis 4 explores the influence of the delivery model characteristics in predicting the occurrence of performance trade-off and thus mission drift. Following from Hypothesis 1 and 2, the expectation is that the model has a moderating effect on the negative relationship between the social and financial performance indicators.

***H4: The type of delivery model has moderating effect on the relationship between financial and social performance***

The four hypotheses are linked to the delivery model specifications and analyzed according to the research model on Figure 10.



*Figure 10: The Research Model*

This Research model is developed by analyzing the mission and strategic goals of the five organizations as a central requirement by the Balanced Scorecard. Furthermore, the social and financial perspectives are represented by the indicators in the four dimensions of the Scorecard. Thus, the following analysis merges the literature on performance with the Balanced Scorecard model as the only holistic performance management model existing so far.



## Analysis

The following empirical analysis is based on five cases. First, the data collected from the organizations and through interviews is discussed. Secondly, the empirical cases are presented through a Health Microinsurance scheme overview of design and operations. The following qualitative analysis of social and financial performance is developed through the Balanced Scorecard and the performance practices of the organizations are presented individually as well as patterned according to the Mutual and Partner-Agent model characteristics. The empirical evidence is further structured in order to provide evidence to the research hypotheses that are concluded at the end of the chapter. Last but not least, the analysis finds the reason for the revealed trade-off in performance management practices by the Health Microinsurance organizations.

## Overview of the collected data

The data for the case study companies has been grouped according to the delivery model the organizations belong to and presented in that pattern. This is in tone with the usual application of the case study method which involves a detailed explanation of each case company before generalizing on common patterns. The data has been generalized but nonetheless, non-standard aspects of the case studies will be brought into the discussion where applicable.

After the cases are presented in detail, the empirical data is structured into two building blocks representing the Mutual and Partner-Agent delivery models. Further on, the data is patterned and presented through the framework of the Balanced Scorecard. This framework is developed from the angle of the balance between social and financial performance depending on the delivery model. Such presentation supports a structure for empirically proving the presented hypothesis.

The data was gathered through interviews with specialists, enablers, managers and CEOs of HMIs in India. Throughout the analysis, the author will be using information in the form of statements from those interviewees in order to support the arguments.

## The Empirical Cases

The population consists of five organizations operating in various states of India. A quick overview of the four organizations in question is presented in Table 7.

Criteria/Scheme	PREM	UpLift	BASIX	MicroEnsure
Type of scheme	Mutual	Mutual	Partner-Agent	Partner-Agent
Type of organization	NGO	NGO	MFI	Microinsurance Intermediary
Years of experience	10	9	7	1
Area of intervention	Dalits, Tribals in Odisha	Pune Slums and rural areas in Maharashtra	17 States of India	Maharashtra, Andhra Pradesh, Tamil Nadu
Premium per year	30 Rs. per person for family	100 Rs. per person for family of four	130 Rs. per person	211 Rs. per person
Coverage per year	3,600 Rs.	15, 000 Rs.	2,500 Rs. hospitalization cash cover; 25,000 Rs. accidental hospitalization	20,000 Rs.
Number of insured	150,000	110,000	Over 150,000	195,000
Origin of subsidies	PLAN International	ILO; InterAid	Royal Sundaram Alliance General Insurance Company	District Community Cooperative Bank
Management of funds	Self	Self	TPA, Insurance Company	TPA, Insurance Company
Compulsory /Voluntary	Compulsory	Compulsory	Compulsory	Compulsory
Access to health services	Pre-authorization	Referrals are encouraged	Pre-authorized	Pre-authorized
Payment mechanism	Cashless/ reimbursement	Reimbursement	Reimbursement	Cashless
Hospitalization coverage	3,600 Rs	Lodging, Nursing, Medicine, Investigations, Guidance for preventive care	Hospital Cash Benefit, Accident Hospitalization	Yes
OPD coverage	Yes, Free	Yes, Discounted	No	No
Maternity coverage	Yes	Yes	No	Yes
Discounts	50% on medicine	20% on medicine	No	No
Health related additional activities	Health camps; Educational programs	Referral, Preventive care, Guidance doctor, 24x7 Telephone Helpline	Child Education Benefit	Health camps

Table 7: Program Design

The fifth organization that was interviewed over e-mail operates through the Partner-Agent model. Mahasemam Trust, which is a MFI providing Health Microinsurance in Tamil Nadu, is included in the case analysis wherever the data provided brings evidence for proving the hypothesis of the research as the information that Mahasemam has provided is not sufficient for a thorough case analysis. The second MFI, BASIX, was also willing to share only limited amount of data. This again proves the lack of interest from the MFI-led model towards Health Microinsurance.

Even though the four organizations on Table 7 can be grouped two-by-two in the Mutual and Partner-Agent model they are very different from each other which leads to within model differences in the analysis. It is important that each organization is presented in detail in order to understand the difference in the mission and strategy of each organization as discussed in the next section and thus, the intramodel differences in variables that affect the performance practices.

The Uplift Health Insurance Program, HMF, is one of the most discussed schemes in the sector when it comes to performance measurement. This community managed health microinsurance program pools risk across more than 100,000 members in Maharashtra State, India. This program is a mutual insurance program. The HMF program involves three main actors: Uplift India Association, a platform that provides all the back-office services and support for the insurance program and thus the organization of interest to this study; NGOs that provide the insurance as an integral part of their microcredit programs, like APVS and PSW; and low-income families who purchase, use, and participate in the management of the insurance (i.e., the community). The HMF program provides access to lower cost in-patient and out-patient healthcare as well as a variety of health management services to low-income, informal sector workers and their families living in Pune's slum areas. The HMF product was introduced in 2003.

At Uplift, clients make decisions about premium rates, network healthcare providers, claims approval and reimbursement amounts. The HMF program has a governance system in which the policyholders, led by their own representatives, review and decide on the final disposition of all claims. The financial component or insurance provides cover for in-patient healthcare costs of up to 15,000 Rs. for a premium of 100 Rs. per family member. The term of the insurance is one year and runs concurrently with yearly loans. The HMF product is mandatory for most microcredit borrowers. Purchase of an HMF policy entitles Insured members to low cost or discounted in-patient treatment at network hospitals as well as eligibility for 80 to 100 percent reimbursement of claimable costs at these facilities. The network out-patient doctors, drug stores, and labs provide price discounts ranging from 7 percent to 20 percent for HMF members.

Insured members are encouraged to obtain referrals before seeking hospital care in order to hold down medical costs for the policyholder and to ensure that the patient receives appropriate and quality care. Members can obtain a written referral by contacting their Service Executive (SE) at the NGO branch office, through calling a 24/7 Helpline, or from the Uplift Guidance Doctor. The Uplift referral feature is particularly important in the Indian context where the medical sector is largely unregulated resulting in vast price differentials for the same treatment at different facilities.

Uplift has put into place a number of other free of charge activities to promote better preventative health behavior among members. These services include health education talks and access to free screening, diagnostic and health services through health camps, as well as the Guidance Doctor mentioned above (McGuinness, 2011, Uplift website).

The other Mutual case studied in this research is the People's Rural Education Movement (PREM) and their innovative approach that has been chosen to contribute to the progressive extension of health protection to all in India. PREM is targeted towards Adivasis, Scheduled Castes and small and marginal farmers. This was done by organizing community-based organizations into federations at apex levels. Embedded in a wider health promotion program, PREM initiated in 2002 an innovative health insurance targeting the poor tribal population spread over two districts in Orissa. It is a comprehensive program which covers preventive and promotive health care along with curative treatment while ensuring a deep sense of ownership among its members. This in-house scheme is one of the few using public health facilities to deliver health care service covered under the insurance plan. The scheme also innovated in setting up some 500 Village Medicine Depots run by trained volunteers aiming at ensuring doorsteps availability of essential medicines at affordable prices. This still unique experience in India is seen as a major factor explaining the scheme's success in enrolling the local population with high renewal rates observed over the years. It is a mandatory scheme: all families in a village must enroll in the scheme. Premium to be paid for each member of the family was set at 20 Rs. per family member in Years I, II and III and 30 Rs. per family member in Year IV. The strong solidarity traditions existing in tribal villages instill a sense of ownership and thus ensure a large membership basis, prompt premium collection and prevention of moral hazard.

The service delivery is structured in three levels: 1) treatment at the Village Medicine Depot (VMD) by a trained community volunteer; 2) if the patient is still sick after 3 days he gets transferred to the nearest public or private health facility; and 3) transfer to the District Hospital or Medical College. All costs incurred at hospital level are covered up to 3,600 Rs. In exceptional cases where surgeries have to be performed for a higher cost, PREM may decide to extend the cover up to this new level. Besides that the program covers all transportation costs.

To support and stabilize the scheme, PLAN International (India) has been paying seed money for six years on a progressively declining basis. PREM has recently been approached by the state government to look at the possibility to expand its activities to a larger BPL (Below Poverty Line) population. Discussions are currently under way with both the State Government and the Central Government (ILO report).

MicroEnsure is the world's first microinsurance intermediary. MicroEnsure has introduced a unique in-patient cashless health microinsurance product in conjunction with SHARE Microfin, a leading Indian MFI, District Community Cooperative Bank and Medicare TPA. The product operates in the states of Maharashtra, Andhra Pradesh and Tamil Nadu. The product was expanded to include distributional channels like Calcutta Kids, an NGO working with slum dwellers, and Church Southern India serving fishing communities in Kerala. The scheme covers 195,000 clients.

Within India, the TPA system has enabled providers with MicroEnsure to sell and service health microinsurance that costs 211 Rs per person on a floater basis. This system allows flexible payment options for families of different sizes and those unable to afford to pay the premium in a single lump sum. The product was the first in India to cover maternity and pre-existing illness from the first day of coverage. The scheme is only in-patient and does not include OPD consultations. However, there are included additional services such as regular health camps with General Practitioners on diabetes, heart diseases, cataracts, etc (Will de Klerk).

The use of a slum-based NGO and religious groups to sell voluntary health microinsurance proved that alternative channels other than MFI's exist to reach the poor. However the product is mandatory and credit linked.

Health Insurance services were initially launched in 2005 to provide risk management support to the credit clients of Bhartiya Samruddhi Finance Limited (BASIX). At present the MFI partners with Royal Sundaram Alliance Insurance Company and the scheme operates in most states of India. In 2010 BASIX received over 150,000 claims. The cover includes the spouse of the borrower in order to enhance the household coverage. The 130 Rs premium covers 2,500 Rs hospitalization, 50,000 Rs for permanent accident disablement, 25,000 Rs Accidental Hospitalization, and 10,000 Rs Child Education Benefit for up to 2 children in a family upon the death of the member due to accident. There is non-exclusion for pre-existing diseases for hospital cash benefit. However, there is first year exemptions waived for hospital cash benefit.

The scheme's administration is outsourced to Third Party Administrators (TPA) whose job is to visit the insured in the hospital in order to facilitate the services and at the same time to verify the credential of the claims. However, the Health Microinsurance offered is suffering from high administrative costs given the current health delivery system and the lack of unique identity for citizens (in e-mail with D. Sattaiah).

Despite the lack of information on the Mahasemam health insurance scheme, it is suggested that this Partner-Agent model is designed to cure vulnerable diseases, not including any precautionary treatment and offering only in-patient services. As the members of the scheme do not realize the health risk coverage as their vital priority, the scheme is mandatory to all credit clients. Mahasemam differs from the other two Partner-agent schemes by offering an alternative to hospital accessibility through quarterly conducted Health Camps and innovative Telemedicine Centers offered in remote areas where there is lack of healthcare facilities. The mobile clinic vans come with specialist doctors available on satellite for consultation, drugs prescribed through electronic media and available at concessional price, as well as X-ray and scanning facilities (in e-mail with Paneer Selvam).

## **Discussion of Performance Practices**

The following discussion of the five models is structured according to the Balanced Scorecard framework in order to prove the appropriateness of the model use in Health Microinsurance. The industry KPIs and some more specific health related KPIs are presented in the four dimensions of the BSC (see Figure 11). In order to achieve a balanced long term performance, the organizations have to adopt all of the below mentioned KPIs. Furthermore, implementing the BSC model in the organization provides for institutionalizing performance monitoring from management to

operations. It also allows for reflecting on service processes so that more organization specific measures can be created than simply borrowing the industry key indicators. However, this research is seen as a starting point for adopting academic practices within the microinsurance industry and due to lack of organizational data analyses performance through borrowing only industry KPIs. An exception is UpLift as they have started to incorporate their own measures that reflect better their organizational goals.



Figure 11: Balanced Scorecard for Health Microinsurance; Source: Paul Niven (2003), Garand and Wipf (2010), Sandmark & Simanowitz (2010)

### Mission & Strategy

This section analyses the cause and effect relationship between organizational strategy and operational performance as this is essential to understand the trade-off of financial and social performance.

### Mutual Model

“PREM’s vision is the creation of a new social order in which the present unorganized and marginalized people have a say in the decision making” (Annual Report 2009-2010, p.4). Their job is to support and promote human development which is reflected in their motto “Asset to Assetless and Power to Powerless”. This vision is based on values of social justice, equality, truth, freedom and dignity. PREM’s mission to facilitate people to support life so that life may support people is illustrated by PREM’s emblem of a tree that represents life and three men on the one side of the tree and three women on the other side representing the men, women and children who come together to participate

in the process of promoting life. Thus, the organization's mission is to provide support and advocacy so people from tribes and low casts can maintain sustainable and value based development. Some of PREM's strategic goals that are specific to their HMI scheme are (PREM's Annual Report):

- Empowering Adivasi, Dalits and fisher people groups
- Sanitation and healthcare for every community
- Promoting participation of women in the decision-making process
- Defending the cause of children and their welfare
- Promoting indigenous groups for community rights and networking them to achieve their rights
- Implementing innovations in technology in health and livelihood

These explain the special attention given to reproductive healthcare – maternal and child health, knowledge and prevention of HIV/AIDS and other STIs, and awareness building of preventive healthcare through district and state level workshops. PREM's approach to healthcare gives a lot of importance to the Village Self-Rule by training village-level leaders in uplifting their communities through healthcare (PREM's Annual Report). This is an innovative approach that will be discussed in detail in the social performance section of the paper as this is where the program really makes a difference.

The case of UpLift shares the approach of community empowerment as claims are settled in democratic and transparent way by the community representatives. UpLift's vision is very similar to PREM's as the organization strives at *"Enriching Lives of the Poor...together"* and sees its role as an agent to the people and a tool that can better their health and enrich their lives. Deepali Kulkarni, Project Manager at UpLift, adds that the vision is to create a health mutual model that can be applicable globally. This gives main importance to the HMF scheme which is missing in the PREM model. The mission is in tune with the vision as UpLift *"strives to improve the livelihood of the poor people by strengthening the capacity of community based organizations that provide financial capacity building and livelihood development services"* (UpLift's website).

However, the values of UpLift slightly differ from those of PREM as they are more problem-solving and corporate oriented as well as more specific. They include solidarity, transparency, entrepreneurship and respect which are common for the Mutual model but also professionalism and simplicity which specifically reflect concerns of Health Microinsurance. This specificity and promptness of values is what have led UpLift to the position of a leader in HMI performance monitoring.

Another difference between the two organizations is the specific HMI oriented strategic goals of the organization. The first goal is to enrich the lives of 25,000 poor families every year which reflects the issue of outreach that mutual schemes have and shows that the organization is actively trying to deal with this downside of the delivery model. The second strategic goal of UpLift is to assess the improvement of the standard of living of families after intervention on a yearly basis. This is directly linked to performance measurement and connects the very core of the organization to KPIs and performance that is directed towards the shareholders of the organization, the community it serves.

Despite the obvious performance related differences between the two HMI schemes, they both belong to the Mutual model and are useful examples of performance measurement practices within this model. They can be clearly separated from the Partner-Agent Model.

### *Partner-Agent Model*

BASIX's organizational core is a textbook example of the drivers of performance measurement in the Partner-Agent model. Their mission is *"to promote a large number of sustainable livelihoods, including for the rural poor and women, through the provision of financial services and technical assistance in an integrated manner"* (BASIX Presentation). The organization includes the poor but economically active people. It is not based on the community it serves which makes the strive for social returns to step back and give importance to the financial performance as BASIX strives *"to yield competitive rate of return to its investors"*. Thus, the promotion of livelihoods is limited by the competitive rate of return rather as opposed to the Mutual model. At the same time the HMI scheme is only one part of the financial portfolio BASIX offers which leads to not prioritizing the program and paying less than the necessary attention to the program performance. This is supported by the organizational strategy for provision of financial, technical and institutional development services in an aggregate manner so that sustainable livelihoods are promoted (e-mail with Sattaiha). HMI is offered due to customer demand; however, it is not given much importance.

The values that provide a base for the mission and strategy are transparency, customer protection and excellence in services. These are business oriented values and could serve as a foundation of regular performance measurement practices in any insurance company.

The case of MicroEnsure is quite different from BASIX. The mission of MicroEnsure is *"to empower the materially poor to transform their lives by insuring them against financial risk and its consequences"*. MicroEnsure is the only case organization that mentions *insurance* specifically in their mission. Their vision is not based on India but includes *"a world where the materially poor enjoy abundant life"* (MicroEnsure website). MicroEnsure is concentrating on microinsurance of different types rather than only HMI and only in India. However, the organization has the client's well-being at heart and their social mission seems to be the driver of their performance measurement as a Partner-Agent model. This is confirmed by the organization's strategic goal which is to provide a safety net to reduce economic setbacks.

In contrast to MicroEnsure, Mahasemam's vision is quite specific and short-termed. It is to help two million families out of poverty by 2015 (e-mail with Paneer Selvam & Mahasemam's website). It sounds more like a strategic goal that the organization has rather than a long-term vision. The lack of appropriate vision is alerting and leads to doubt of management skills which can reflect in the performance measurement practices of the organization. What is stated as a strategy – *"serving exclusively women who live in midst of poverty"*, sounds more like a way of achieving the strategy.

Mahasemam's mission is *"to provide innovative and sustainable financial services with help in order to empower poor women to eradicate poverty, thus enabling a better quality of life for them and their families"* (e-mail with Paneer



Selvam & Mahasemam's website). Offering an HMI product clearly matches with the mission of the MFI, however, it is only viewed as one tool for poverty eradication just like in the case of BASIX. The MFI is based on values of honesty, excellence, love, affection and patriotism. Neither the values, nor the mission and strategy lead towards performance measurement as an important management tool.

In conclusion, all organizations are guided by their social mission of helping the poor out of poverty which indicates the accuracy of the assumption that the HMI schemes have a social drive. However, performance measurement is based on the mission of an organization and as organizations tend to drift away from their mission, performance should be measured to avoid such drifting (Denis Garand; Pim Engels, 2010). On the other hand while looking at strategic goals and values, some organizations have set specific strategic goals towards the HMI, while others are concentrating on a financial tools package. This can lead to the risk of non-accurate performance monitoring and bargaining with client value and viability of the scheme. At the same time there are essential differences between the organizations in the two models which should be kept in mind.

The next section develops on the performance measurement assumptions as deduced from the mission and strategy of the models and discusses in more detail the actual performance measurement practices of the five organizations.

### Customer Dimension

On the social level, as confirmed in interviews, the need to satisfy and protect members (owners) of Mutual organizations is primordial. In this sense, although the incurred claims ratio is used to keep tabs on the health of the mutual insurance reserves, there is a clear sense that as much of the premium as possible should be returned to members in the form of claims payments. When the claims ratio is too low, a social interpretation that emerges is that it may be the case that members do not understand the insurance product and are therefore prone to making ineligible claims or visiting hospitals outside the network of hospitals that UpLift, for example, has signed agreements with. A higher claims ratio is believed to lead to better client satisfaction and renewal rates. The industry target ratio is 60 percent and a higher ratio is considered as not sustainable in the long run. The claims ratio for UpLift is 63 percent. The claims incidence has been increasing slightly for PREM during the years as well. This is due to the provision of services at primary healthcare level which has decreased the number of referrals (ILO). BASIX scores around 70 percent which is even higher. Despite the claim made by D.Sattaiha that the insurance is completely sustainable for them as well as for the insurer, the scheme cannot remain sustainable in the long term. Such high ratio can only be supported by heavy subsidization of the insurer. Furthermore, when the claims ratio is too low, in addition to members losing out on financial returns, there are growth related issues with the scheme which can lead to the need for partially restructuring.

Utilization is monitored regularly through the Identity Cards provided to clients of the schemes. Each record is kept related to the ID Card and is updated every month (Kulkarni & Jacob Thundiyil). Utilization is of most importance to MicroEnsure as it shows the share of clients applying for claims reimbursement. The claim incidence ratio for MicroEnsure is 1.7 percent which is about the same as BASIX at 1.54 percent. Both organizations are off the scope of

the industry target which is 2 percent, the exact number performed by UpLift. The case of BASIX raises the question of whether the members understand the program and how to use it or whether their health awareness is high enough. MicroEnsure is not sure what the reason for underutilization is but some other options can be no provider access, lack of diagnosis as lack of OPD or choosing alternative method of treatment. Whatever the reason, Will de Klerk shared that their insurer partner is not keen on making the clients more aware of the insurance product and provoke higher utilization. This is because the commercial insurer is legally obliged to insure a certain amount of people due to IRDA regulations but there is no incentive to invest in a sound insurance scheme. PREM's incidence ratio is 3 percent which signals possibility for adverse selection. It has been shared by Jacob Thundyil that about 10-15, 000 people get sick per year and they all get sick at the same time due to seasonal diseases. A related indicator that PREM follows is the number of immunizations provided to children which is specific to the schemes target audience.

The renewal ratio indicates the level of customer satisfaction with the product and checks if it adds any value for clients. Interviews conducted for this research mostly dismissed this indicator as having any relevance because members are not yet given the choice of enrolling voluntarily in the programs and cannot take out health insurance without taking a loan from one of the implementing organizations (Bert Opdebeek). It is however important to monitor in order to raise management awareness in case of any anomaly numbers and to create a routine in monitoring in case of future development of voluntary programs.

The renewal ratio can however change even for mandatory schemes, for example when whole groups or villages drop out at the same time. There is a sense, moreover, that renewals carry no greater weight in a mutual than they would in any other type of microinsurer. The high enrollment and renewal ratio for PREM is considered to be due to the 500 Village Medicine Depots run by trained community volunteers aiming to ensure doorsteps availability of essential medicines at affordable prices (ILO). Such innovation can be considered as essential to all Mutual schemes as medicine costs normally amount up to some 45 percent of the healthcare expenditures born by households (WHO). Also, the renewal ratio is tricky to follow especially in the case of the Partner-Agent model where the insurance is linked to a microloan and as the people who borrow change; there is a shift in membership within the insured group (Will de Klerk).

The renewal ratio can provide an insight on how the organization should approach the education of clients. If organizations monitor renewal they know who is a new comer and needs education on the importance of microinsurance and who has been in the scheme from previous years and should be provided with deeper knowledge of the scheme. In this way organizations can avoid wasting resources on education and providing the necessary information (Bert Opdebeek).

The calculated coverage ratio for UpLift in 2010 is only 6.6 percent which gives significant opportunities to the organization to expand its outreach. PREM is currently covering 150,000 people predominantly from tribal areas. The number of member decreased dramatically over the last three years due to some fishermen communities dropping

out of the scheme and therefore a new focus was set on tribal groups. As with UpLift, PREM is planning to expand to 500,000 people provided the opportunities for scaling up. At the same time PREM is in process of reaching partnership with the Ministry of Health and Family Welfare in order to develop a national intervention which could expand the HMI's outreach dramatically.

Although one would expect a Mutual offering microinsurance in a poor community to have a duty to ensure that the poor, not to say the poorest, are being included, this is not always the case. There are competing interests in any community, slums included, and community based organizations can easily replicate exclusionary practices (Bastiaensen et al, 2005). The poverty outreach ratio, in this sense, will have two potential effects, depending very much on the leadership and ambitions a mutual develops. Firstly, in a community based mutual that does not include the most vulnerable, who in the case of insurance can cost too much in claims payments, or just cannot afford the premium, the poverty outreach ratio can be used to illustrate the exclusionary nature of the mutual. Alternatively, in a mutual keen to include all members of the local community, even those that bring greater trouble, the ratio can be used to track progress towards greater inclusiveness.

UpLift has been trying, not without difficulty, to make sure that a section of its members comes from societal strata living below the poverty line which includes Standard of Living Level (SLL) 1, 2 and 3. At present UpLift reaches only level 4 and 5 (Deepali Kulkarni). Attempts, however, are made to reach level 3 by offering premium reductions (Bert Opdebeek). What are revelatory, however, were the conflicting views on reaching the poorest that emerged. Whilst the French donor organization InterAide is keen that a percentage of HMF members come from below the poverty line, managers of the implementing organisation APVS seem to find poverty measurements a nuisance. In contrast, at PSW, which is far less focused on growing its membership than APVS and retains a strong anti-commercial vision, there is deliberate policy to count the number of poor members reached. This policy is backed up, with support from the donor, with a 40% discount on premiums, although it must be said that the poor are reached more through the offer of very small loans than the offer of discounted premiums (Yan Gelister, 2011). The interview with UpLift revealed that there is a powerful desire to help the most vulnerable people of the slum, which translates into greater flexibility in interpreting policy rules for those, who as a result of their poverty, might not be as empowered as others to benefit from the mutual. There is also widespread knowledge among elected representatives that the mutual exists to serve the poor, unlike some of the organizations in the Partner-Agent model. The poverty focus of a mutual, it can be said, will in a way be the result of ongoing negotiation between members and those that are put in place to manage *their* organization.

Poverty outreach has been criticized by insurance specialist as mentioned earlier. Therefore the example of UpLift dividing people into salary groups is very plausible but not generalizable. There is, however, a need of developing different outreach groups depending on the organization's target audience instead of relying on poverty outreach alone.

UpLift shows that the degree of institutionalization that has been attained with the organization's own social performance indicators is in part due to the exigencies of running a mutual. Given the mutual reserves belong to the community, there is, as seen earlier, a dual incentive to pay out as much as possible in claims whilst also protecting the mutual fund. This can explain the creation of two indicators that straddle the social performance, namely out of pocket expenses (OOPEs) incurred by members and amount saved by members through the use of network hospitals. Both indicators are unique to UpLift among health microinsurers. Based on its ability to aggregate demand for healthcare providers, UpLift negotiates discounts with private hospitals, out-patient doctors, drug stores, and medical laboratories. Thus, the OOPE represents the concessions amount in the context of claim amount settled and OOPE. On the one hand, OOPEs must be kept low for members so that they have costs kept to a minimum, a significant dimension of added-value for the client (McGuinness, 2011, Deepali Kulkarni). This is done by paying them as much as possible in claims and by educating them to use network hospitals. This dynamic is therefore crucial for client value. The network concession lowers the OOPE cost when clients go to pay their hospital bill, and the claims reimbursement is lower, thus protecting the claims fund. Importantly, this is well understood by UpLift management and by community representatives, although there is still an excessive and burdensome use of non-network hospitals. What is clear, and common to the two member-based organizations, is that paying for membership comes with expectations of returns. At UpLift, the decision to provide non-financial services for members can be seen as attempt to live up to member expectations and enhance the non-claimant microinsurance experience. Indeed, there is feeling within UpLift that, as compared to commercially oriented microinsurers, it is incumbent on a mutual to offer non-financial services. At the same time as it is recognized that non-financial services are almost a minimum condition in a mutual Health Microinsurance organization, it is important to point out that such services, in the case of UpLift, could not be provided without external subsidization from InterAide.

PREM does not measure OOPE or the amount saved as they are dealing with BPL customers and deal with a different set of issues. They concentrate on the decline of death ratios amongst infants and mothers during childbirth amongst members which has dropped down to 0 cases due to the HMI's healthcare services. Thus, the mutual services are geared towards improving the health prospects of members. As much as these services are indispensable from a health point of view, it turns out that they appear to be underused, at least in the case of UpLift (McGuinness, 2011).

The provision of such non-financial services does suggest the role for the social investment ratio, which at present is not used consistently at UpLift and is not at all measured by the rest of the organizations. A recent study by Microfinance Opportunities calculated the UpLift social investment ratio to be 13.9 percent in 2010 (McGuinness, 2011) which shows the share of total expenses devoted to information, education, and health prevention activities. Amongst the advantages community embeddedness can offer, perhaps participation, democratic control, proximity to the client base and a focus on local economic development are the most obvious. In the case of Health Microinsurance, working together as a community should also increase bargaining power vis-à-vis healthcare providers (ILO). On paper, these traits are compatible with the social bottom line. Whilst the ownership and

involvement of the community did indeed have many positive effects, there were also suggestions when analyzing deeper the rejection ratio that community participation was more elusive than first thought (McGuinness, 2011).

In order to develop further on the issues behind some of the Key Performance Indicators of Social Performance the author suggests the application of the PACE model which has been tried only by UpLift so far. Application of the customer value tool on more organizations than UpLift can further develop the PACE model and eliminate its weaknesses while improving management understanding of the microinsurance processes.

MicroEnsure takes the social performance to a higher level by looking at health impact of the overall health status of the population. This, however, is out of the scope of the study as it is a costly long-term process for which there is not enough existing information yet. It demands an epidemiological analysis over time on yearly basis and in comparison with other populations (Will de Klerk). Nevertheless, such an analysis is recognized as the ultimate research of any Health Microinsurance initiative. A possible tool for analyzing long term outcomes is the MILK client math, which provides information about the financial value provided at the time of a claim of products in comparison to alternatives or develops an Impact study to assess the outcomes on indicators related to behavior change or wellbeing of communities.

### Internal Process Dimension

With regard to the promptness of claims settlement ratio, mutual ownership of the insurance fund can be said to have an effect of social performance. Given the duty to protect reserves, a mutual must make checks on claims that reduce the scope for moral hazard and adverse selection. At the same time, a mutual like UpLift (with a set standard for paying claims of 50 days) has a duty to be transparent with the membership, which explains the claims making process being public and under joint control of UpLift staff and community representatives. Not all claims in UpLift were settled within the 50 days target due to requirement that all members of the policyholder's group be in attendance for the claim to be disbursed (McGuinness, 2011). There is therefore a slight trade-off between having a solid claims payment process open to the community, which also has an educational function, and having a swift process that respects member cash flows. In a mutual, the promptness of claims ratio, which is also indicative of how efficient operations are from a financial perspective, carries a double meaning in social terms, which is not the case in the Partner-Agent model. BASIX's turn-around-time (TAT) is only 30 days from the risk event to claim settlement, out of which 10 days is at the insurer side (BASIX presentation). This with no surprise shows a leaner reimbursement process than in the case of Mutual organizations. However, the prompt payment of claims is contrasted by the high claims rejection ratio.

MicroEnsure is a cashless scheme and the promptness of claims settlement ratio should not be applicable. Nevertheless, an operational issue has been discovered as some of the partnering hospitals demand money from the scheme members, who on the other hand send claims to MicroEnsure. There is a need to support the TPA to ensure that the members get cashless access as this is an important feature when it comes to customer impact because the

poor are further indebted by borrowing money for the treatment. Thus, MicroEnsure needs to develop a referral system together with the supporting TPA that encourages customers to prefer those hospitals that offer cashless access.

The UpLift case suggests a need to add measuring the promptness of claims declaration in HMI schemes. This together with the claims settlement indicator demonstrates the length of time that the client would spend without the cash and possibly owing creditors in the case of reimbursement schemes.

Insofar as the rejection ratio is concerned microinsurers must be wary of how many, and in what way, member claims are rejected. Yet as Mutuals operate in closed communities, where gossip is rife, the effect of a single rejection can undo the positive marketing resulting from many paid claims. The incentive is to keep as many members happy as possible. This tendency does have its downsides. In practice, claims are seldom rejected. The consequence is that claims payments are spread out over a larger number of claimants, meaning that each claimant, given the finite nature of what are still fragile reserves, tends to be reimbursed less than what she should be paid based on policy rules. If this is important for collective member buy-in because of the demonstrative effect that insurance pays (and therefore works), it does leave members with large claims short-changed. This behavior seeks to increase the impact and outreach of the program by increasing the number of beneficiary households. It also aims to increase member satisfaction in order to improve renewal rates and ensure the sustainability of the program. This is an attempt to strike a fine balance between outreach, sustainability and impact. The rejection ratio for UpLift is 4.6 percent (McGuinness, 2011) while the one for BASIX is 9 percent (BASIX Presentation) which shows that BASIX clients may not have sufficient knowledge about the rules of the scheme. Such a high rejection ratio may have an adverse effect on the customer satisfaction. BASIX has not conducted satisfaction study on its HMI separately but in an overall research including other financial products and services. They do not have assigned Monitoring and Risk Management team individually on the HMI either (D. Sattaiha).

UpLift also calculates complaints ratio on annual basis. Complaints are collected through the 24x7 telephone helpline or through complaint questionnaires at the provider. The implementing organizations gather all forms and data and send them to UpLift in hard copies. The ratio is between 60 and 80 percent (Deepali Kulkarni) which is rather high but could be explained with lack of awareness and understanding of how the scheme works by clients.

As MicroEnsure does not have a fraud control mechanism of that kind due to the Partner-Agent model it tracks abnormality in diagnosis by monitoring the kind of claims filed. They compare their data with other HMIs in the region, like RSPY, in order to see if the different diseases and their incidence are normal for the type of population they serve (Will de Klerk).

In the case of PREM, the community embeddedness has put pressure on public hospitals through service demand to become more functional and improve the quality of services. At the same time the members push for more efficient

healthcare delivery. The scheme trains community volunteers in recognizing pills for common disease symptoms through a color-coded system due to their illiteracy, which is an innovative way of developing awareness about healthcare within tribal societies (Jacob Thundyil).

## Finance Dimension

The combined claims ratio for UpLift in 2010 is above 100 percent (McGuinness, 2011) which makes it not sustainable in the long term. In the case of UpLift a higher premium in 2011 will decrease the claims ratio and ensure viability of HMF. That was realized by UpLift looking at two performance indicators that are not industry KPIs: claims size and claims frequency (or claims incidence which was discussed earlier). Such conclusion, however, puts a question on the appropriateness of the program design. Furthermore, the rest of the organizations analyzed are also expected to high combined ratios. This can be related to the early maturity level of the market.

The incurred expense ratio is the key indicator of program efficiency that is based on simple accounting of inflows and outflows. According to Dennis Garand this is a sensitive ratio as it provides a vivid idea of the holistic performance of the HMI scheme within one number. Comparing the organizations on the expense ratio provides a clear view over the level of viability of the organization. The industry standard has been set at 20 percent although it is stressed that the ratio for HMIs should be higher than for other microinsurance programs (Garand & Wipf, 2008). The ratio for UpLift is 31 percent which implies that the scheme is not sustainable yet and that donors are funding the 11 percent of excess in operating costs (McGuinness, 2011). These ratio calculations mean that the mutual scheme will not be self-sufficient in its operations unless there are economies of scale. In the case of UpLift this can happen by reaching 300,000 clients which can be achieved through the expansion of existing partners as well as through the acquisition of new partners (McGuinness, 2011).

Based on operating expense per member UpLift's HMF program was 78 percent operationally sustainable which shows that with a slight increase in premium the operations will become sustainable. PREM also benefits from a progressively declining lumps sum provided during the first six years by PLAN International. According to latest calculations the grant amounts to 10.5 Rs. per insured (ILO). With a premium of 30 Rs. the program becomes roughly 75 percent operationally sustainable. Despite that Jacob Thundyil insists that the premium is sufficient. The reason for this might be that the seed money have been used for payment of health services while the premium collected has been invested in mutual funds and the return of these schemes will be used for ensuring the self-sufficiency of the scheme (ILO).

None of the organizations in focus monitor the net income ratio which is considered as very important by enablers (Bert Opdebeek) and the commercial insurers (Angove and Tande, 2011). In addition, as organizations do not monitor essential financial indicators as liquidity and solvency, their reserves are not set properly as to meet future financial obligations. That, however, is not considered as a major concern at present as the HMI schemes are still growing and the premium amount increases every year (Bert Opdebeek).

This research assumes that the lack of financial indicators monitoring by the agents discussed in this section is because that is the responsibility of the commercial insurer as a partner with skills in risk management. Therefore, the financial performance of the Partner-Agent model is considered to be more expansive than the Mutual model.

### Employee Learning Dimension

Staff retention ratio is not a concern to UpLift which has 13 highly-motivated and devoted employees and a few international trainees. The permanent staff consists of actuaries and doctors who receive training in back office process and sourcing. However, the ratio is an issue for the HMF implementing organizations as in the past there have been communication gaps and mismatch in salary expectations. The way that UpLift plans to overcome that is through hiring and training people from the community that have more passion for the field than already established specialists (Deepali Kulkarni). UpLift's PCMs (Partner Community Members) are the elected community representatives responsible for deciding on member claims. Most often, PCMs already have important roles in, and the trust of, the community, which explains in part why they put their names forward to manage claims. In addition to having a crucial role in the operations linked to claims processing, PCMs also play an active part in member education, as they are often the first port of call for members with questions regarding the HMF. PCMs volunteer their time, and importantly UpLift offers them bi-monthly training on microinsurance and health to build their skill-set and empower them to better serve their community.

The role given to PCMs is designed, in part to bridge any gaps that might emerge between UpLift staff and HMF members. They are key to building trust. The signature of the PCM on any claim is also a way of demonstrating that the organization remains non-for profit, a fact that is reassuring to members keen to avoid the relations of exploitation they associate with profit-driven companies (McGuinness, 2011 and Gelister, 2011). PMCs are also used as fraud control mechanism as in such system it is the community that decides who is going to get money so fraud opportunities are limited.

PREM is operating on similar premises. Their village-level volunteers work for free and under the same principle as the PCMs in UpLift. At the same time the federation and district level workers are hired full-time and work on salary.

There are no volunteers in the Partner-Agent model and there is no data available on staff retention and it does not seem to be monitored. However, effort is placed in training back office employees. Furthermore, although the industry immaturity is the reason for lack of monitoring of this category as well as lack of enough indicators, it is considered to be an important drive for innovation in the long term. Thus, indicators and monitoring practices for Employee Learning need yet to be developed.

### The Performance Balance

Since Financial and Social KPIs overlap there should not be place for much trade-off between financial and social performance. If the organization is performing well on the one side, it should automatically be doing well on the other side (Denis Garand & Bert Opdebeek). However, as the above analysis reveals all organizations are missing on



monitoring many of the suggested KPIs. UpLift, the organization with most control over performance measurement, is missing ratios for financial performance such as net income ratio, growth ratio, solvency, liquidity as well as KPIs on social performance like rural outreach, transparent sales ratio. However as the organization is under the Mutual model and struggles to reach enough scale it has understandably chosen to concentrate on social rather than purely financial performance.

UpLift is designing a standardized protocol for each service through both back and front offices through close monitoring procedures for the last 9 years while PREM uses the Microinsurance Factsheet as a template for data collection. However, PREM's data is not as well standardized as UpLift's. Thus, PREM plans to improve their management information system by adopting the software developed by UpLift (Mutual Fund management System) which is meant for community-based organizations willing to engage in the progressive development of a common health insurance database (ILO). The development of such system should include a model like the Balanced Scorecard but when asked the interviewees admitted that they have not heard of the Balanced Scorecard as a term.

Will de Klerk shares an opposing opinion on the willingness to benchmark in India. As MicroEnsure's HMI in India has only one year of experience they need to compare data on diseases and their incidence with other HMI schemes to see if there is something abnormal in the numbers. However, they have experienced that schemes are not willing to share their data. This kind of behavior leads towards market competition amongst HMI organizations.

Furthermore, the case of MicroEnsure shows that there is a mismatch of interest in their Partner-Agent model. According to Will de Klerk the HMI scheme is not sustainable due to lack of interest from the insurer side. As long as the insurer fulfills their social obligation posed on them by IRDA, they do not bother to base the premium on market pricing which creates issues to the underwriting performance, product development and pricing strategy of the scheme. Such behavior limits the social intentions of the scheme for the sake of financial viability.

On the other hand, the collective ownership in a Mutual induces the social interpretation of financial performance indicators and at the same time affects the choice to use mostly social performance indicators. As previously observed, the low rejection rate due to community embeddedness, leaves members with large claims short-changed. This phenomenon points to the difficulties of balancing social performance in a mutual grappling with equitable treatment of members with good financial value for clients. Questioning a high rejection ratio might seem flawed from a financial perspective ratio for the mutual, but in the long run it is crucial that members feel they can trust the mutual to accept their claim. In the same way, a high renewal ratio, obviously good for HMF reserves, also means that there is less effort to be done on educating members, which will result in lower costs. The social interpretation of the promptness of claims ratio, which stressed swift claims processing, is also compatible with its financial interpretation, which seeks to limit back office costs by processing claims faster. An indisputable benefit from monitoring social performance indicators, in particular UpLift's own OOPes and amount saved statistics, is that the organization is able to limit costs all around. This is the case for members and for UpLift itself, which by monitoring the amount saved by clients and the amount spent of their own pocket, is able to renegotiate prices with hospitals if and when it is

appropriate, or simply strike the more costly hospitals off the network. These particular social indicators are therefore crucial in minimizing costs to the mutual in the long run. Moreover, once systems are set up to monitor these indicators regularly, the costs of doing so are minimal.

Despite all the advantages of social performance management for a mutual network like UpLift, it would be remiss not to reflect on two important drawbacks. The first is that UpLift continues to be subsidized by a donor. Sustainability is threatened in part on donor dependence, but also by the fact that claims payments remain high as compared to earned premium, a fact that can only be altered either by increasing premiums (which would likely be contested by members) or reducing claimable amounts. Recent research suggests that UpLift is also not operationally self-sufficient, but that a possible solution is to grow the current membership of around 100000 members to 300000 members (McGuinness, 2011). Yet we have seen how maintaining social performance and a strong community focus are partly contingent on maintaining a small scale. What is more, the lack of growth, and the associated scale economies it can create, is also preventing PSW from paying out claims in line with claimable amounts, which reduces the financial value received from the HMF by members. These realizations gathered through social performance monitoring question towards the financial viability of social performance and the negative relationship between those.

According to the Client Value Webinar participants, which was organized by the ILO, the balance of cost and client value depends on the context of the different models and schemes so no one method can be generalized. However, such balance seems possible in the long term. The commercial insurers from the Viability Webinar seem to agree with such statement and add that the issue of trade-off between social and financial performance, or outreach and viability, relates to the issue of time. As the scale increases, a technological development of the operations will follow which on its turn will decrease expenses. In this way insurers will be able to redistribute resources as to meet customer expectations and create client value.

However, it also seems that the more subsidies the scheme has access to the higher the operational costs, as there is no incentive for efficiency through innovation, as the funds are guaranteed. As the case of ICICI Lombard, presented by Alok Agarwal during the Viability Webinar, indicates scale by commercial insurers can be achieved with less subsidizing than presently provided. Subsidizing in the beginning can bring economies of scale but too heavy subsidizing discourages innovation and sufficient decrease in operating costs. Therefore it is essential for donors to find the right balance.

Furthermore it does not seem like many donors demand concrete performance results as is the case in microfinance. The take up on performance indicators in HMI is low or in some cases only the convenient indicators are measured. This is a difference from microfinance, where it is the investors that demand a serious application of performance indicators. There is the existence of the MIX market, a global benchmark database, which was tried to be translated in microinsurance but is ending as an attempt that has not prospered in microinsurance at present. Bert Opdebeek provides as a reason the fact that in most types of microinsurance the premium is enough to pay out most of the

claims and donors are only involved in one part of the delivery channel so they do not feel responsible for the performance of the product in organizations they do not support.

Exception seems to be made by Leapfrog and the ILO who demand from the insurance scheme to invest in performance measurement and report on it regularly. It is important for the success of microinsurance to learn from and avoid the situation of microfinance and the critics of mission drift. It is not enough to simply calculate a performance ratio but also integrate it into the Internal Management System and realize what lies behind the number and how a bad result can be changed. Performance measurement should not be just seen as an investor demand but should be taken seriously as having impact on the business development.

Besides the high costs of the schemes from the Partner-Agent model, they also offer low access to healthcare for poor people and score average on product and service experience (Client Value Webinar). This can sometimes be due to not aligned expectations between the partner's and the agent's mission and goals, as is the case of MicroEnsure.

Another issue in measuring financial and social performance is the use of different measures by different organizations. The example of commercial insurers that measure the viability of their schemes bring along two conclusions about their performance measurement: 1) there is no intention of measuring social value at present as the organizations are legally obliged to have a social mission but are not provided with an incentive to follow it; and 2) there is use of different financial KPIs from those suggested by the Performance Indicators Working Group as there is more reliance on financial indicators than on social measures. This is an example that the Mutual schemes might need to learn from commercial insurers and equip themselves with more insurance relevant skills and tools. This could provide the Mutual schemes with considered competitive advantage.

The universal doctrine states that access to health is a fundamental human right. Therefore, it should be the duty of the government to provide healthcare to everybody. Thus, there is the threat that microinsurance schemes will be overwhelmed by a national operation in about 10 years which implies that the microinsurance should be designed as complementary and not competitive to national health insurance. The consequences of this are that the microinsurers' duty is to create money for subsidizing poor people on the demand side as well as intervening on the supply side of healthcare by raising the service standard in public and private hospitals (Will de Klerk). However the intervention within public hospital has not have much progress since there is lack of qualified management that can monitor the performance of services which leads to quality system deterioration. Therefore, it is necessary to expand capacity at the lowest level through community health workers, as in the Mutual model of PREM and UpLift, in order to avoid working with hospitals. That, however, requires more attention on the social mission of Health Microinsurance and stronger social performance awareness by Partner-Agent organizations.

As for Mahasemam Trust, all indicators that they follow are according to the microfinance framework for performance measurement: poverty index scale, loan and asset appraisal, activity appraisal, repayment track of client, delinquency

and causes, customer satisfaction survey (Paneer Selvam). These are not applicable to microinsurance as the two types of business are very different and demand different types of indicators. This means that there cannot be any discussion of performance measurement of Mahasemam HMI scheme as no separate data is conducted and available by the organization. Such management is consistent with the problems indicated in the Partner-Agent model, especially the lack of importance given to HMI by microfinance organizations.

Table 8 summarizes the performance measurement practices of the five organizations and the result from the table are used for creating a benchmark of the performance data collected from the organizations.

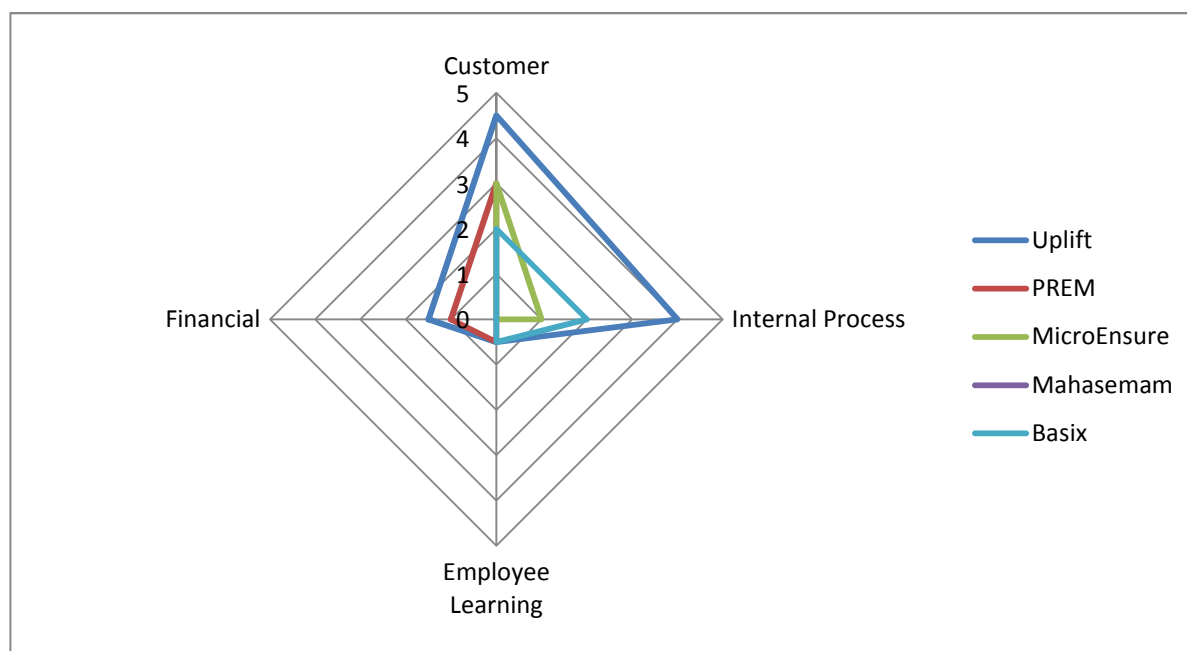
	<b>UpLift</b>	<b>PREM</b>	<b>MicroEnsure</b>	<b>Basix</b>	<b>Mahasemam</b>
<b>Customer</b>	1) Incurred claims 2) Claims incidence + size 3) Renewal 4) Coverage outreach 5) Poverty outreach according to salary levels +OOPE 6) Social investment	1) Coverage 2) Claims incidence 3) Claims renewal 4) Social investment is discussed but not measured	1) Claims incidence 2) Claims renewal; claims size + cashless; 3) Social investment is discussed but not measured	1) Incurred claims 2) Claims incidence	No
<b>Internal Processes</b>	1) Promptness of claims settlement + claims declaration 2) Complaints ratio 3) Claims rejection	No	1) Claims diagnosis	1) Claims rejection 2) Promptness of claims settlement	No
<b>Financial</b>	1) incurred expense + operating expense per member	1) Operating expense per member	N/A	N/A	No
<b>Employee Learning</b>	Discussed but not measured	Discussed but not measured	No	Discussed but not measured	No
<b>Performance Measurement Practices</b>	Need to break down outreach further & develop social investment as well as measure	No internal processes monitored; no employee learning monitored; need for	Lack of measures discussed for financial and employee dimension; not sufficient	Concentrated on financial performance	No specific measures on the HMI scheme; all KPIs are on microfinance activities

	employee learning and break down the financial indicators	monitoring more specific customer and financial KPIs	information provided on internal processes; no ability to concentrate on social value		
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*Table 8: Performance Measurement Practices according to the Balanced Scorecard Framework*

Although all four dimensions are important for a balanced performance, it can be argued that under certain circumstances some dimensions are more important than others for a specific HMI scheme. However, what is important in the long term is a balanced performance measurement proposition, a scheme that scores well on all dimensions. Given this assumption and for the sake of simplicity, the dimensions of the Balanced Scorecard are treated equally. Moreover, as mentioned earlier the framework assumes that all schemes are guided by their social mission to provide healthcare opportunities to the poor.

The scoring uses a five-point scale and criteria on all 18 KPIs, including the two specific to HMI KPIs, developed by the microinsurance industry. While it is plausible to assume that all four dimensions are almost equally important for the balance of social and financial performance in the long term, not all 18 KPIs carry the same level of importance. This is realized as a weakness of the benchmarking framework introduced here. That is due to lack of sufficient in-depth information of the schemes which can be gained only through field research and a longer timeframe. However, based on the data collected so far the performance practices of the five case schemes are compared on Figure 12.



*Figure 12: Evaluation of Performance Measurement Practices of the Five Case Organizations*

According to the data provided it seems that the Mutual model, led by UpLift, has developed a more advanced measurement system specific to the Health Microinsurance performance challenges. It should be, however, explicitly

mentioned that the benchmark is created at organizational level rather than delivery model level, even though the hypotheses are approached at model level. It might be too inaccurate to analyze at model level because of the insufficient amount of data about the other players in the delivery models. Despite the low financial performance measurement of the Partner-Agent model organizations, at model level they are assumed to possess strong practices of monitoring financial indicators. This is due to the partnership with commercial insurers that have good actuarial skills and monitor mostly insurance related viability. Thus, despite the confusion created by Figure 12, the primary assumptions of the research on the differences between the two models and the performance issues related to those are indeed confirmed. Furthermore, the trade-off between financial and social performance in Health Microinsurance is also confirmed.

Such benchmarking of performance practices has its downsides provided that many of the organizations in the industry have created their own definitions, indicators and tools to measure those. It is, therefore, important for a further research to establish whether that is the case and create an appropriate leveling method.

Another issue in benchmarking that was pointed out by Denis Garand was the high number of KPIs which impedes benchmarking and blurs the idea of Key in Performance Indicators. Therefore he recommends that some of the KPIs as they are defined now are dropped out of the framework. Each organization should, of course, break the KPIs down to specific measures and create measures that fit the process performance.

## Implications and Revisiting the Hypothesis

The conclusion on the research hypotheses is based on empirical data from the five cases, drawn upon the Balanced Scorecard and the PACE tool with focus on financial and social performance.

### ***H1: The type of delivery model has an impact on financial performance***

The two mutual organizations do not monitor purely financial indicators. The financial dimension indicators that they consider are related to managing expenses. Managing reserves is not taken seriously yet. Having in mind, that a lot of the social and financial indicators are overlapping, however, indicates that there are some financial performance considerations at least as long as they relate to client value, as illustrated by UpLift. PREM on the other hand is lacking the Internal Process indicators measurement which should be changed with time.

The two MFIs presented in the Partner-Agent model do not pay much if any attention on the performance of the HMI schemes alone. Furthermore, MicroEnsure is monitoring primarily in relations to the impact of the HMI and its utilization. Thus, it is assumed that it is the commercial insurer that is responsible of the financial performance measurement. As illustrated by ICICI during the Viability Webinar, insurers monitor primarily financial indicators of liquidity, solvency, net income and pay particular attention to reserve management, with little consideration of the social mission of the HMI schemes. Therefore, considering the limitations in the collected data, it may be concluded that the Partner-Agent model is more inclined to monitor financial performance than the Mutual model.

### ***H2: The type of delivery model has an impact on social performance***

The two mutual models seem to be more concerned with their social performance and the client value that they can offer. UpLift is considered a performance measurement pioneer in the Health Microinsurance industry in India. They have broken down the industry KPIs into organization specific measures and have incorporated them into a standardized management system which deals with the issues signaled by the indicators so that they can be taken action on after a thorough research. PREM is planning to adopt the UpLift performance software in order to better organize their performance monitoring which would also allow for sharing performance data among mutual schemes.

MicroEnsure also pays extra attention on the appropriateness of the scheme and its ability to meet client needs. They closely monitor health impact and utilization which is much lower than in the mutual schemes. Thus, MicroEnsure feel limited by the Partner-Agent model. BASIX on the other hand monitor only overlapping social and financial performance indicators with the prospect of ensuring financial viability as the scheme benefits are limited to low-occurrence, high-financial burden accident-related reimbursement. Such benefits design help some of the poor but do not have much effect on healthcare quality or overall healthcare status of the population and are, thus, considered of limited social value. As for Mahasemam, they provide advanced health related additional activities which might create some social value but the result is unknown as the MFI does not monitor any performance indicators of their HMI. Thus, according to the empirical evidence collected so far, the Mutual schemes are somewhat more advanced in monitoring social performance. It is certain that the duty of managers in a mutual towards their membership is more subject to accountability than is the case in the Partner-Agent model.

### ***H3: A negative relationship is found between financial and social performance***

PREM is an example of a good social performance in terms of depth of outreach, including the poorest of the poor, but also facing challenges due to that. The HMI scheme is negotiating more financial support from the government at state and national level in order to provide better benefits and to expand its coverage. This is a clear trade-off between social and financial performance in Health Microinsurance.

In the case of UpLift, one of the challenges is related to the promptness of claims reimbursement due to community embeddedness which provides social value to clients but might hurt the viability of the scheme in the long term. Another trade-off between social and financial performance in Mutual schemes comes from the legal restrictions in India that impede the schemes from scaling up faster, and thus, from reaching financial sustainability.

MicroEnsure faces a different challenge related to the trade-off between service utilization at a rate that provides value to customers and financial viability of the scheme which is controlled by the commercial insurer. The scheme offered by BASIX is claimed to be viable, however, it also provides low utilization, low depth of outreach and relatively low social value. Therefore, there is a negative relationship between financial and social performance in Health Microinsurance at present and an existing risk of mission drift in the future.

### ***H4: The type of delivery model has moderating effect on the relationship between financial and social performance***

Considering the above empirical analysis and following the conclusion from **H1** and **H2** it can be deducted that the Mutual model has achieved a better balance of social and financial performance. The community-based HMIs monitor social performance closely, as dictated by their social mission and community embeddedness as shareholders. This has led to better innovation in product design suitable to the less fortunate of the poor which is achieved with less subsidization in order to reach operational viability in comparison to the Partner-Agent model. However, the downside is that the Mutual model faces difficulty in reaching scale and might need to be re-organized.

The Partner-Agent models discussed enjoy a larger scale; however, they are also less in-touch with clients and provide services that do not always bring along social value. This model has a better grasp on the purely financial indicators as it is abandoned with professional insurers. Thus, the delivery model has an effect on the relationship between financial and social performance of the schemes. Nevertheless, more research and richness of data is needed in order to prove such a dependency.

The conclusions from the empirical analysis on the hypotheses that structure this research are provided on Table 9.

Model/Hypothesis	<b>H1:</b> The type of delivery model has an effect on financial performance	<b>H2:</b> The type of delivery model has an effect on social performance	<b>H3:</b> A negative relationship is found between financial and social performance	<b>H4:</b> The type of delivery model has moderating effect on the relationship between financial and social performance
Mutual	Negative effect	Positive effect	Yes	Yes
Partner-Agent	Positive effect	Negative effect	Yes	Yes

**Table 9: Conclusion on Hypothesis**

As indicated by the analysis there is not only intermodal differences when it comes to performance measurement but also intramodel differences amongst the different organizations of the two models. This is due to the difference in strategic goals and mission of the organizations. Therefore, the performance indicators should be created individually for each organization. However, there is also need for generalization of the performance data through benchmarking in order for development of the market. This shows that there are organizational differences that should be considered but there is also need for creating patterns between models and measures in order to bring along performance balance in Health Microinsurance.

The reason for the low development of performance measurement practices and the trade-off between social and financial performance is the product or market maturity of Health Microinsurance in India. The conclusion of this research is also confirmed by the participants in the Client Value research of the ILO. The maturity of the Indian market is still at early stage and yet it is far ahead compared to the rest of the developing world (Bert Opdebeek). Despite the immaturity of the industry, the Microinsurance Performance Working Group encourages organizations to implement performance scorecards, the balance of which should come with time and experience. The level of maturity of the HMI market in India as found in this research is illustrated on Figure 13.





Figure 13: Stages of development and capacity requirements; Source: Microinsurance Conference, *Rupalee Ruchismita*

As illustrated by the Figure Health Microinsurance has still a long way to go. There is the need to develop industry specific factors, such as transparency and disclosure, consumer protection, data collection as well as attracting actuaries and professionals, which will assist better performance measurement and management practices. In this, the goal of the above research has been to provoke academic discussion of possible balanced performance solutions in the industry.

## Conclusion

The purpose of this thesis has been to shed more light into performance measurement pitfalls in Health Microinsurance. That was done by, first of all, by introducing the characteristics of HMI programs, the reason for their existence and purpose they have to fulfill as social protection mechanism while being led by market mechanisms in order to reach scale. The business case of such organizations is still unclear, considering that none of them has reached financial sustainability yet. However, they are serving the fraction of the Indian population that has been completely ignored until about ten years ago and are, thus, considered to bring social value by offering access to healthcare. Moreover, there are numerous issues that the organizations need to face at economic, political and legal context. Those challenges are more or less relevant depending on the organizational model of the HMI scheme. Some see HMI's future in a public-private partnership because as discussed healthcare is considered as a universal right that should ultimately be offered by the government. Therefore cooperation and innovation is essential to the development of the sector.

Secondly, the delivery models were discussed and the Mutual and Partner-Agent model were chosen for the level of analysis since they are the most popular in the Indian context. The Mutual model is community-based and efficient in identifying and meeting community needs at low transaction costs. However, it faces a challenge of sufficient outreach and growth because of its community embeddedness and lack of legal recognition from IRDA. The Partner-Agent model, on the other hand, is financially sustainable due to subsidies and recognition by the insurance authority. It meets larger numbers of scale but suffers from fraud, conflict of interest between the financial / non-financial mix and covers only emergency healthcare risk, while prevention and healthcare awareness is the real problem of the poor. Thus none of the models is optimal and the model choice depends on the context and the organization. The research explored further the performance measurement practices of HMI schemes relying on the intermodal differences presented here.

Thirdly, the logic of the research considered the performance measures and practices known to the Health Microinsurance market. Those have been developed by the Microinsurance Innovation Facility at the ILO and the Microinsurance Performance Indicators Working Group. They include sixteen Key Performance Indicators for the microinsurance industry that have been used to a different extent by the HMI schemes. Based on the performance indicators, the PACE model was developed to recognize the social value amount added by organizations. This tool is quite new and needs further application in a larger number of organizations in order to be developed and recognized. Furthermore, there is only the typical insurance actuarial model used for analyzing the financial viability of programs. The social and financial performance has not been presented from a holistic angle yet as discussed by the win-win line of thought amongst institutionalist and welfarists. Previous research on the balanced performance is nearly lacking as institutionalist claim the achievement of initial financial viability to be the way to reaching scope, efficiency, lower operational costs and eventually higher social value through a more appropriate and affordable benefit package. Those supporting the welfarist view have argued in the opposite, namely, that providing high and sustainable over

time social value is the key to long term financial viability. This points at the nearly lacking balanced performance view in the sector at present. Thus, there is a need to recognize the Balanced Scorecard as an appropriate framework for incorporating the issue of social value and financial viability.

Therefore, the research continues by exploring the actual financial and social measurement practices by separating the empirical data according to the Mutual and the Partner-Agent model in order to discover dependencies between the type of delivery model and the performance measurement of organizations. It was found that there are intramodel differences in the performance measurement pattern due to the difference in the mission of the organizations which reflects in different strategic goals. This on the other hand affects the design of the scheme, the target group, the utilization, the services offered, the organizational processes and, thus, the interest in measuring different aspects of performance. Despite the difference between organizations, the overall assumption that the delivery model characteristics would affect the performance measurement is also proved. The Mutual model is found to stress on measures that bring to social value or use financial measures only through the social value lens as it is constrained by model characteristics. The Partner-Agent model led by a commercial insurer who applies their actuary and professional insurance capabilities to monitor the more financial performance measures without applying much innovation other than constraining the non-profit agents to low utilization and social benefit levels in order to keep the sustainability levels.

This relationship between the type of delivery model and the performance measurement implies that the delivery model has an effect on both social and financial performance as well as on the relationship between the social and the financial indicators. The data analysis also provides evidence of the negative relationship observed between social and financial performance in four of the five cases that were selected. This is in line with the conclusions drawn on MFI performance in microfinance. In order, for Health Microinsurance to avoid reputational challenges due to mission drift practitioners need to employ holistic tools that can monitor the balance in the performance measurement from the early organizational stage of development in which the industry is positioned.

The good news is that many of the organizations have employed performance measurement to some extent. However, there is a long way to go in order to get to performance management. During the Microinsurance Conference in Rio de Janeiro in November 2011, the *Microinsurance Performance Indicators Working Group* changed its name to *Microinsurance Performance Working Group*, dropping out *Indicators* in order to refocus the goals of the Working Group. This brings along hopes for development towards performance management in the sector.

With this said, the current study is only a minor step forward in trying to better understand the balance of performance measurement in Health Microinsurance. The research is not providing a complete set of possible measures for Health Microinsurance. However, it is important to look in-depth in the service processes at organizational level, break down the key process steps and create adequate measures for each and every HMI scheme

in order to make sure that the right things are monitored. This implies the need to research at both organizational and industry level. Such a research, however, demands familiarity with the organization and the industry through long term field research which is not feasible for this short-term thesis project. Therefore, there are numerous weaknesses related to the empirical data and the data collection method.

For once, the findings would be more reliable with a larger dataset of organizations which has been a challenge to find since not many of the organizations are eager to share data or are aware of performance measurement as a management tool. The research is focused on organization specific information and characteristics rather than on global data and cannot be generalized as even the state to state differences in Indian are tremendous. Moreover, the data would be more valid if there is sufficient quality of data so that a mixed method including quantitative assessment can be used in the analysis. Even more important is the need to find specific indicators that characterize the delivery models in order to quantitatively compare those against the performance indicators and find strong numerical relationships. In a larger dataset that can be achieved through regression analysis.

Besides the data and analytical restrictions, there is also the limitation of the tools suggested for performance management. There is a need of an analytical system that can overcome the difference in financial and social performance measurement methodologies and rating scales used by the individual organizations. Nevertheless, this research is an important starting point for raising academic interest in the problem of holistic performance management in Health Microinsurance and should be viewed simply as a recommendation for further research.

## Annexes

### **ANNEX I:**

Differences between Conventional Insurance and Microinsurance; Source: IAIS (2007), McCord and Churchill (2005); Ahuja (2005)

<b>Conventional Insurance*</b>	<b>Microinsurance</b>
Premium collected in cash or mostly from deductions in bank account	Premium often collected in cash or associated with another transaction such as a loan repayment or asset purchase; Collection modes should respond to the market's irregular cash flows, which may mean frequent premium payments.
Sold by licensed intermediaries	Often sold by unlicensed intermediaries.
Agents and brokers are responsible for sales and services. Direct sales are also common.	Agents manage the entire customer relationship, perhaps including premium collection. Microinsurance is often directly sold to groups.
Targeted generally at wealthy or middle class clients in emerging markets.	Targeted at low-income persons in emerging markets.
Market is largely unfamiliar with insurance in emerging markets. Only corporate customers are familiar with insurance.	Market is largely unfamiliar with insurance and therefore requires a heavy investment in consumer education.

<b>Conventional Insurance*</b>	<b>Microinsurance</b>
Screening requirements may include a medical examination	If there are any screening requirements, they would be limited to a declaration of good health. Some health conditions may only be covered after the insured has had continuous coverage for certain period of time.
Large sums insured	Small sums insured.
Priced based on age/specific risk	Community or group pricing; in case of individual pricing often higher premium due to risk level of policy holders and lack of competition on supply side.
Limited eligibility with standard exclusions	Ideally broadly inclusive, with few if any exclusions. In reality, there are often exclusions, e.g. related to age and kinds of treatment.
Complex policy document	Ideally a simple, easy to understand policy document. Often though, this is not yet the case.
Claims process may be quite difficult for policy holders	Claims process should be simple while still controlling for fraud. In reality, claims processes may still be complex.

\* Not applicable for large group insurance.

## **ANNEX II:**

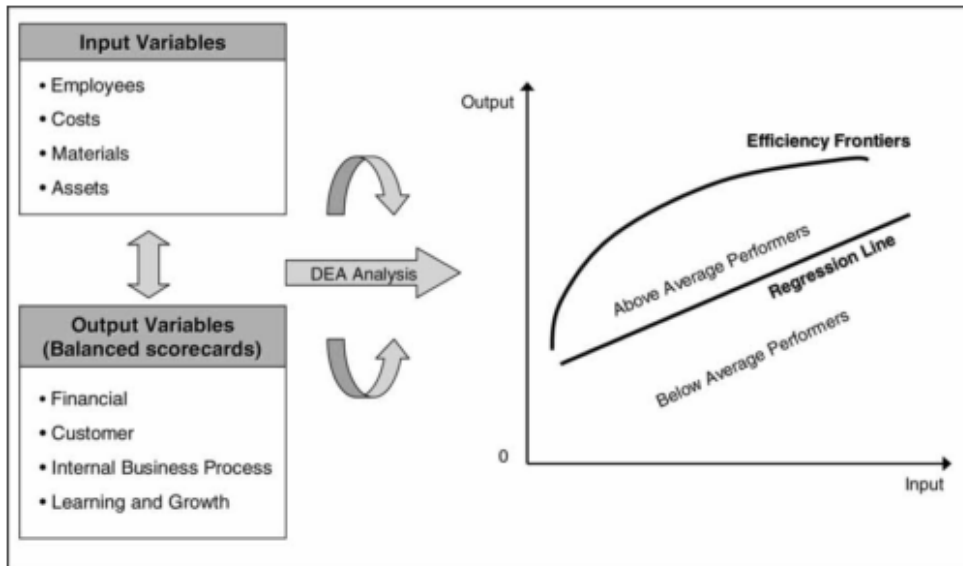
Indicators for monitoring a Health Insurance Program; Source: Devadasan & Nandraj, 2006

Indicator	Definition	Monthly	Annual
Coverage rate	Number of people enrolled in a defined population		+
Penetration rate	Number of people enrolled from among the target population		+
Distribution rate	Number of people enrolled per distributor		+
Enrolment trend	Trend over the years		+
Renewal rate	The number of people who are renewing their membership		+
Member satisfaction	The number of members who are satisfied with the services	+	
Insurance card rate	The number of members with an insurance card		+
Quality of claims	The number of claims with the proper documents at the first instance	+	
Utilisation rate	The number of members who fell sick and required care	+	
Claims rate	The number of members who fell sick, and have claimed insurance benefits for their illness episode	+	
Reimbursement rate	The number of members who have been reimbursed their claims	+	
Median medical costs	The median costs of hospital bills	+	
Referral rate	The number of patients who were referred	+	
Quick ratio	The ratio between the liquid assets and the liabilities	+	
Administrative expenses ratio	The ration between the administrative expenses and the total expenses		+

### **Annex III:**

Balanced Scorecard and DEA

Source: Chiang & Lin, An integration of balanced scorecards and data envelopment analysis for firm's benchmarking management, Total Quality Management Vol. 20, No. 11, November 2009, 1153–1172





## **Annex IV:**

### Overview of Interviews and E-mails

Title of interviewee	Interviewee name	Organization
Project Manager	Dr. Deepali Kulkarni	UpLift
CEO	Jacob Thundyil	PREM
Industry Expert within Microinsurance Financial Performance	Denis Garand	Denis Garand & Associates
Vice President Health	Will de Klerk	MicroEnsure
Industry Expert, leader of the Microinsurance Network Performance Indicators Working Group	Bert Opdebeeck	brs - solidarity based banking & insurance in developing countries
*Vice President	Paneer Selvam	Mahasemam Trust
*Vice President	Sattaiah Devarakonda	BASIX

**\*Due to language and time restrictions of the participants the interview was substituted by e-mail correspondence (see below)**

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### ***E-mail Correspondence with Mahasemam Trust:***

#### **1. The organization & challenges**

##### **The Health Micro insurance scheme**

The Insurance schemes of Insurance companies are separately dealt with Health and Life risk coverage. No single policy or single company wherein, coverage for both is provided. More over as far as Health, the policies are designed to cure vulnerable diseases rather precautionary treatments. The policy does not assist or motivate poor to go for preventive actions to ail from diseases. In microfinance all along the premium for Health and life risk policies were borne by NGOs out of profits generated from their activities, classifying as welfare scheme to safeguard the interest and welfare of poor clients. Under the new RBI regulations fixing uniform interest for all lending transactions, the profitability is not restored as earlier. Hence premium for risk coverage needs to be remitted by the concerned members. The members do not realize the risk and health coverage as their vital priority. Moreover, as far as of Health, unless they put in serious diseases, women do particularly least bother caring their health status regularly. Leaving aside of health, risk coverage is invariably applicable to all since the collateral free loan is treated as risk component to compensate loanes after their demise. Voluntary effort has not yet been shown by poor families and women in particular for the risk coverage.

##### **· How are the offered services used by clients?**

As regard of Health, the poor seek for health care at the last resort. Depending upon the nature and seriousness of the disease, the probability of risk endures the life of human being. However, they tend to access the services as in patient in the hospital for their ailment. Regular checks are not being availed by them on periodical basis irrespective of the gender.

#### · Other projects currently undertaken by the organization

As far as Health point of view, more coverage is extended to life risk. Hospital accessibility is extended by starting Tele medicine centers in remote areas where the health facility is least. Else, they are to travel far off distance to reach the service. Mobile clinic vans are arranged with X - ray and scan facilities. Drug is available in the clinics readily at concessional price. Doctors who are specialists are available to them on satellite and consultation being done face to face and drugs prescribed on electronic media. Health camps are conducted every quarter with qualified medical practitioners to treat their health needs. In addition to health, all the members of the program are insured against life risk. More over this, educational support, skill building training, and gender indiscrimination are also provided to them.

## 2. Risk management

#### · What indicators or measures do you track?

Poverty Index scale  
Loan and asset appraisal  
Activity Appraisal  
Repayment track of client  
  
Delinquency and causes  
  
Customer satisfaction survey

#### · How are those tracked? Internal system, when, for how long, etc?

Internal system exercised periodically with finance auditors, risk management staff every quarter.

## 3. Performance measurement

#### · Mission, core values, vision, strategies

**Mission:** To provide innovative and sustainable financial services with HELP in order to empower poor women to eradicate poverty, thus enabling a better quality of life for them and their families.

**Values:** Honesty, Excellence, Love and Affection and Patriotism

**Vision:** To HELP two million families out of poverty by 2015.

**Strategy:** Serving exclusively women members who live in midst of poverty.

#### · Client & client value

Member who proves their sound credit track  
Higher loan for viable activities  
Home loans for the deserving disciplined members  
Educational support for their children  
Skill building and market linkage to the right enterprises  
Study conducted to ascertain their requirement and satisfaction  
Assessment to ensure the status growth in their life  
Women members are treated with good pride and dignity

<p>· <b>Internal processes that you concentrate on</b></p> <p>MIS</p> <p>Day to day monitoring using customized software</p> <p>Regular monitoring, auditing, and supervision</p> <p>Ensuring attendance of members in centre meetings</p> <p>Applying social peer pressure for all decisions</p>
<p>· <b>Financial means and social objectives</b></p> <p>Finance is raised from financial institutions as loans against hypothecation</p> <p>No support of grant or aid to supply credit at concessional rate of interest</p> <p>Social objective is poverty alleviation through economic and non economic services</p>
<p>· <b>Employee skills</b></p> <p>Operational skill</p> <p>Arithmetic skill</p> <p>Sympathy and empathy skill</p> <p>Social skill</p> <p>Auditing skill</p> <p>Communication Skill</p> <p>Honesty and Patriotism</p>

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### ***E-mail correspondence with BASIX:***

<b>The organization &amp; challenges</b>
<p>BASIX is facilitating, as an insurance corporate agent, two kind of health insurance products.</p> <ol style="list-style-type: none"> <li>1) Group product where a simple procedure is employed to enrol a person as a member for coverage under the terms of Master Policy. Under this policy, the similar coverage is given to the clients.</li> <li>2) Retail individual policies where the policies are sold to individuals with varied coverage based on customer interest.</li> </ol> <p>We have tie-up with Royal Sundaram Alliance General Insurance Company Ltd., for all non-life insurance products and with AVIVA Life Insurance Company Ltd. For all life insurance products Ltd.,</p> <p>The responses to the queries based on our experience of offering the above services for the last 7 years.</p>
<b>The Health Micro insurance scheme</b>
<ul style="list-style-type: none"> <li>• Health insurance awareness is low in India and slowly building up.</li> <li>• Willingness to pay for health insurance is still a rare thing among low income families.</li> <li>• Admin cost of health insurance is high given current health delivery system and lack of unique identity for citizens.</li> </ul>

<b>How are the offered services used by clients?</b>
<ul style="list-style-type: none"> <li>The health insurance services benefits are utilisation has been steadily growing over the years. Cumulatively over 150000 clients benefited in terms of claims settlement for the medical needs.</li> <li>This product programmes is seen as a beneficial and proved to be a demonstration in terms of effect of the insurance.</li> </ul>
<b>Other projects currently undertaken by the organization</b>
Company is providing all kinds of other insurance services including life insurance, asset insurance, livestock insurance and weather insurance as part of strategy of providing risk management services by BASIX. BASIX follows a strategy of providing financial, technical (capacity building) and risk management services.
<b>Risk management</b>
<b>What indicators or measures do you track?</b>
<p>The underwriting risk is taken by the insurer. However, the following operational measures are taken for reducing the risks.</p> <ul style="list-style-type: none"> <li>Deploy a cadre of claims facilitators who act as THIRD Party Administrators (TPAs) whose job is to visits the insured in the hospital to facilitate the services and at the same time verify the credential of the claims.</li> </ul>
<b>How are those tracked? Internal system, when, for how long, etc?</b>
<ul style="list-style-type: none"> <li>These are tracked following each such claim. Claim Facilitators report to the insurer and based on which the claims gets processed.</li> </ul>
<b>3. Performance measurement</b>
<b>Mission, core values, vision, strategies</b>
<ul style="list-style-type: none"> <li>Mission: Promotion of livelihoods</li> <li>Vision: Equity (capital) for equity (equality)</li> <li>Values: Transparent, customer protection and excellence in services.</li> <li>Strategy: Provision of financial, technical and institutional development services in an aggregate manner so that sustainable livelihoods are promoted.</li> </ul>
<b>Client &amp; client value</b>
All those who are poor but economically active are our target clients. We are committed for provision of services to enhance his/her lively hood levels.
<b>Internal processes that you concentrate on</b>
Processes are customer friendly and committed to continued improvements.
<b>Financial means and social objectives</b>
Our vision reflects that. All our services are expected to result in sustainability of the livelihoods which meets both social and financial needs.

<b>Employee skills</b>
Employee skills are key in delivering value proposition to the clients. And we are assessed to be good on the same.
<b>What are BASIX responsibilities when it comes to measuring performance of the health microinsurance. Do you follow up on any indicators or you are just a distribution link and the insurers are the ones following on sustainability, efficiency and value creation?</b>
Bhartiya Samruddhi Finance Limited (BASIX) responsibility begins with enrolling persons for coverage, communicate on features, facilitate lodging claim and forward to insurer. We follow up indicators on 1) Turn Around Time (TAT) for claims settlement, % of claims rejected and also the product performance in terms of payout % in terms of premium collected.
<b>You state “This product programmes is seen as a beneficial and proved to be a demonstration in terms of effect of the insurance.” Have you done any studies on impact and are they published?</b>
There is no separate study done on micro health insurance alone. However, the same is covered in customer impact study where complete perspective of customer is drawn on the product, its performance. An internal team called MRM (Monitoring and Risk Management) team would constantly capture customer feedback on all financial products and services offered by the company.
<b>Is your health insurance financially sustainable and if not is the insurer covering the whole loss?</b>
The health insurance product is completely sustainable both for the insurer and for BASIX as a distributor. Currently the out go for claims is around 70% of the premiums collected.
<b>Can you describe the process of providing the insurance from your side?</b>
<p>Group Insurance: Each of the credit clients is enrolled for insurance coverage issuing a membership certificate with details on coverage. The customer pays the premium on a monthly frequency as long as the credit service account is active (outstanding) and performing.</p> <p>In case of retail product, BASIX sales person sells the insurance product to the persons on upfront premium payment and the premium is remitted to the insurer on a daily basis through an advance floating account. An insurance coverage certificate is given to the client and the policy document is sent to the client by postal service.</p> <p>BASIX staff is informed on the claims, if any over a phone. BASIX claims facilitator visits the hospital to collect the needful details and sends a report to the insurer’s claim processing office.</p>
<b>Are you aware of the Key Performance Indicators promoted by the Performance Indicators Working Group of the Microinsurance Network? What is your opinion on that?</b>

BASIX is one of the leading organisations contributing to micro insurance knowledge repository from time to time in various national international forums.

## **Annex V:**

### Overview of Secondary Data:

<b>Health Microinsurance Organizations in India</b>	
Peoples's Rural Education Movement	<a href="http://www.prem.org.in">http://www.prem.org.in</a>
UpLift India Association	<a href="http://www.upliftindia.org">http://www.upliftindia.org</a>
MicroEnsure	<a href="http://www.microensure.com">http://www.microensure.com</a>
Mahasemam Trust	<a href="http://www.mahasemam.org">http://www.mahasemam.org</a>
BASIX Consulting & Training Services Ltd	<a href="http://www.basix-consulting.com">http://www.basix-consulting.com</a>

<b>Microinsurance organizations</b>	
The Micro Insurance Academy (MIA)	<a href="http://www.microinsuranceacademy.org">http://www.microinsuranceacademy.org</a>
The Microinsurance Innovation Facility, ILO	<a href="http://www.ilo.org/public/english/employment/mifacility/">http://www.ilo.org/public/english/employment/mifacility/</a>
Micro Insurance Center	<a href="http://www.microinsurancecentre.org">http://www.microinsurancecentre.org</a>
Micro Insurance Network	<a href="http://microinsurancenetwork.org">http://microinsurancenetwork.org</a>
Microfact	<a href="http://www.microfact.org/">http://www.microfact.org/</a>
Insurance Regulatory and Development Authority (IRDA)	<a href="http://www.irda.gov.in">http://www.irda.gov.in</a>
Access to Insurance Initiative (aii)	<a href="http://www.access-to-insurance.org">http://www.access-to-insurance.org</a>

<b>Commercial insurers</b>	
Allianz Group	<a href="https://www.allianz.com/en/about_allianz/sustainability/microinsurance/importance/page1.html">https://www.allianz.com/en/about_allianz/sustainability/microinsurance/importance/page1.html</a>
ICICI Lombard	<a href="https://www.icicilombard.com/">https://www.icicilombard.com/</a>

<b>Microfinance organizations</b>	
MIX Market	<a href="http://www.mixmarket.org">www.mixmarket.org</a>
Dansk Forum for Mikrofinans	<a href="http://www.mikrofinans.dk/">http://www.mikrofinans.dk/</a>
Financial Access Initiative	<a href="http://financialaccess.org/">http://financialaccess.org/</a>

<b>Webinars and presentations</b>	
Client Value Webinar, ILO, May 2011	<a href="http://www.youtube.com/watch?v=fZF93Oa4VbM">http://www.youtube.com/watch?v=fZF93Oa4VbM</a>
The Viability of Microinsurance Webinar, ILO, November 2011	<a href="http://www.youtube.com/watch?v=-ObJr4Vl18">http://www.youtube.com/watch?v=-ObJr4Vl18</a>

<b>Newspaper articles</b>	
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Kiviat, B. 2009, "Why the World's Poor Refuse Insurance", <i>Time</i> , September 21, 2009	
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Yadav, K. 2010, "A Micro Presence", <i>The Financial Express</i> , July 25, 2010	
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<b>Publications</b>
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<b>Smith Chamberlain, Extending Microinsurance Distribution and Client Value</b> <a href="http://wn.com/Microinsurance_Extending_Microinsurance_Distribution_and_Client_Value_Chamberlain_Smith">http://wn.com/Microinsurance_Extending_Microinsurance_Distribution_and_Client_Value_Chamberlain_Smith</a>
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## **Annex VI:**

Formulas to calculate selected social performance indicators:

<b>Rural outreach ratio</b>
$\text{Rural outreach ratio} = \text{Number of clients living in rural areas} / \text{Total number of clients}$

<b>Transparent sales ratio</b>
$\text{Transparent sales ratio} = \text{Number of clients who have received information prior or during purchase} / \text{Number of new clients}$

<b>Incurred expense ratio</b>
$\text{Incurred expense ratio}_n = \text{Incurred expenses}_n / \text{Earned premium}_n$

<b>Liquidity</b>
$\text{Liquidity ratio}_n = \text{Available cash or cash equivalents}_n / \text{Short-term payables}_n$

<b>Solvency</b>
$\text{Solvency ratio}_n = \text{Admitted assets}_n / \text{Liabilities}_n$



**Net income**

$$\text{Net income ratio}_n = \text{Net income}_n / \text{Earned premium}_n$$

**Growth ratio**

$$\text{Growth ratio}_n = (\text{Number of insured}_n - \text{Number of insured}_{n-1}) / \text{Number of insured}_{n-1}$$

**Staff retention ratio**

$$\text{Staff retention ratio} = \text{Number of employees who have remained} / \text{Average number of employees}$$

**Incurred claims ratio**

$\text{Incurred claims ratio} = \frac{\text{Incurred claims}}{\text{Earned premium}}$

**Claims rejection ratio**

$\text{Claims rejection ratio} = \frac{\text{Number of claims rejected}}{\text{Number of claims under a given product}}$

**Renewal ratio**

$\text{Renewal ratio} = \frac{\text{Number of renewals}}{\text{Number of potential renewals}}$

**Promptness of claims settlement**

Interval	Number of claims	% of total claims
0 to 7 days	___	___%
8 to 30 days	___	___%
31 to 90 days	___	___%
More than 90 days	___	___%
	Total ___	100%

**Coverage ratio**

$\text{Coverage ratio} = \frac{\text{Number of active insured clients}}{\text{Target population}}$

**Social investment ratio**

$\text{Social investment ratio} = \frac{\text{Social investment expenses}}{\text{Incurred expenses}}$

**Poverty outreach ratio**

$\text{Poverty outreach ratio} = \frac{\text{Number of clients under defined poverty line}}{\text{Total number of clients}}$

**Complaints ratio**

$\text{Complaints ratio} = \frac{\text{Number of complaints registered}}{\text{Total number of policies}}$

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