Costs and Benefits of Health Microinsurance Premium Loans and Linkages with Health Providers

CARD's Experience in the Philippines

FREEDOM FROM HUNGER RESEARCH PAPER NO. 10B

By Myka Reinsch with Marcia Metcalfe and CARD staff[1] | June 2010

Focusing on the impact of the MAHP (Microfinance and Health Protection) services on CARD (Center for Agriculture and Rural Development, Mutually Reinforcing Institutions), this paper explores the hypothesis that microfinance institutions (MFIs) can feasibly offer health-related services that "pay for themselves" via a combination of financial revenues and nonfinancial benefits that indirectly improve the MFI's financial position.

We estimate the costs of offering the two packages—a health Microinsurance premium loan, linkage and education on the one hand, and a "preferred provider program" that links microfinance clients to private, primary health care at discounted rates, on the other—and provide information on direct and indirect benefits. We conclude that:

- The PhilHealth premium-loan package will soon be profitable in and of itself and appears to have additional indirect benefits to CARD.
- The Preferred Provider Program (PPP), while not generating direct income, is a low-cost social add-on and marketing tool that also is likely to have other indirect benefits to CARD.

> *"[Microfinance and health protection] touches the core of our clients' needs, and therefore is absolutely core to what we do at CARD."*
>
> —Dr. Aris Alip, CARD MRI President

The PhilHealth package of services carried a net cost to CARD of about US$8,000 in 2009 (its third full year of operation) with 13,651 clients and would have broken even in that year if just 300 additional clients had enrolled. Given the planned investment in intensive growth over the coming years, and taking into account a full allocation of costs and

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contribution to overhead, we project that this package will become profitable in 2012, when about 55,000 clients will be enrolled. When considering only CARD's direct, marginal costs and allocations of existing staff members' time to manage the service (but excluding overhead contribution), the PhilHealth package earned almost $25,000 in 2009. The PPP discount health-linkage package cost CARD about $63,000 in 2009, with 138,000 clients served. We estimate that this service entails a start-up investment of $.73 per client for the first year and an annual maintenance cost of $.17 per client. Evidence from an array of client, staff and health-provider surveys and interviews indicates that these two health-related service packages contribute to CARD-client attraction, loyalty, satisfaction, retention and positive health-seeking and spending behavior, as well as important institutional learning about health insurance and other in-demand services, and positive staff morale.

CARD staff members involved in both the PhilHealth and PPP packages assert that client growth and retention is positively impacted. If merely a 1 percent increase in CARD membership overall were attributable to these services, the PhilHealth package and PPP would be worth over $1.4 million to CARD in "lifetime value" of clients (based on business loan-related profit for the MFI)—handily exceeding the cost of offering them.

This paper is one in a series documenting the costs, benefits and impacts of health protection services on MFIs and their clients. While further experimentation and research are needed on health interventions coupled with microfinance, we believe that these data on the design, costs, revenues and potential other benefits of such services provide promising evidence and a useful reference point for microfinance practitioners in the budding area of integrated microfinance and health.

Introduction

Purpose

This paper documents the costs and benefits associated with CARD's delivery of two distinct sets of health protection services developed and pilot-tested in two different geographic areas of the Philippines as part of the Microfinance and Health Protection (MAHP) initiative in partnership with Freedom from Hunger from 2006 through 2009. The MAHP initiative set out to identify and test health protection services that could be practically and sustainably offered by microfinance institutions (MFIs). Configuration and operation of the services was honed by CARD and Freedom from Hunger over the course of the four-year initiative, and research was conducted to determine the impacts of CARD's health protection services on both the clients (in terms of health and financial well-being) and on the MFI itself (in terms of the expenses, revenues and other nonfinancial benefits to CARD). This paper is primarily concerned with the financial impacts of CARD's health protection services on the MFI itself.

MFI Background

CARD is a conglomerate of related institutions in the Philippines that includes a large NGO offering microfinance services, two regulated microfinance banks, a training and development institute, a business development services arm, and an insurance company offering life, accident, disability, and property insurance. CARD also operates directly and through partnerships with other MFIs in several other Southeast Asian countries. CARD offers a range of credit and savings products to its all-female membership, including *Credit with Education* for clients who take out individual loans in a group setting as inspired by the ASA model

(Bangladesh), and who receive brief, interactive "education sessions" at their weekly repayment meetings. The organization has been an active partner of Freedom from Hunger since 2000. Figure 1 provides basic outreach and financial indicators on CARD.

FIGURE 1: CARD INSTITUTIONAL DATA AS OF DECEMBER 2009*

MFI-wide	
Year MFI established	1986
Number of active borrowers	967,963
Outstanding gross portfolio	81,539,597
Portfolio-at-Risk (PAR-30)	1%
Number of savers	991,474
Total savings deposits	50,889,954
Operational self-sufficiency	117%
Health Protection Products	
Year Started *Credit with Education*	2000
Number of Members in Credit Group Program Receiving *Credit with Education*	882,673
Number of clients with access to the Preferred Provider Program	138,774

**Data as of December 31, 2009 as provided by CARD*

CARD's Health Protection Services

CARD opted to develop two parallel, though potentially complementary, health protection service packages and to test them in two distinct locations. It is anticipated that in the future, both of these complementary packages will be offered CARD-wide, with the PPP making primary health care more affordable and accessible to CARD clients, while PhilHealth ensures that clients who need higher-level care can obtain it and that clients can make use of savings that might otherwise (in the best of circumstances) be blocked as protection against a major health shock, for productive investments.

> *"I joined CARD because it has many benefits; my favorite benefits are the health benefits."*
>
> —Roselyn, CARD client

Health Microinsurance Premium Loan

In a Nutshell

- CARD promotes and facilitates easy, optional, group enrollment for its clients in the national health Microinsurance program, PhilHealth, and provides a loan to cover the $26 annual premium so that clients may pay for their coverage in small, weekly installments and thereby be assured of continuity of coverage.[2]

[2] The PhilHealth insurance, offered by CARD through the government KaSapi program, covers a portion of hospital expenses and limited outpatient services, but does not cover preventive services or doctor consultations outside a hospital stay. The insurance covers the enrolled CARD client and all her household family members. For more information about the insurance product itself, take-up among CARD clients and other outcomes, please see Outcomes of the Insurance Take-Up Survey Administered by CARD MRI. Freedom from Hunger and CARD MRI. September 2009.

CARD's Role

- CARD NGO, Bank and Rural Bank of San Tomas (RBST) all promote PhilHealth and train their clients on how the service works and what to expect, during CARD clients' regular weekly repayment meetings.
- CARD has an established relationship with PhilHealth and administers client enrollment through PhilHealth's KaSaPi program for NGOs. Although CARD clients (and the Filipino population-at-large) could enroll directly in PhilHealth as individuals, this is labor-intensive and impractical for most people.
- CARD collects PhilHealth application forms from interested clients, submits them to PhilHealth for approval, remits the full premium payment directly to PhilHealth and collects weekly payments on the premium from CARD members, as a loan. After originally offering PhilHealth enrollment without the premium loan, CARD determined that its own risk would be better mitigated with such a loan; without it, CARD was in the position of having to advance up to a year's worth of premiums, and if clients did not fulfill their commitment to remain enrolled, CARD had no mechanism to retrieve those lost funds.
- When insurance coverage difficulties arise, such as PhilHealth initially refusing to cover a patient or service, CARD staff assists the client in navigating the PhilHealth system to secure reimbursement. CARD estimates that Account Officers and/or other CARD staff carry out phone calls and other communication with PhilHealth on behalf of about 10 percent of CARD's PhilHealth enrollees.

Value Proposition

- CARD charges 24 percent interest (flat, annual rate) on the PhilHealth premium loan, plus a 1.5 percent "Loan Redemption Fund" (LRF) fee, and the resulting payment of about $.60 per week[3] is added to the member's regular business loan and savings deposit payment, made to a single CARD Account Officer who visits the clients' meetings on a weekly basis. After reaching certain enrollment thresholds, CARD receives a 9.7 percent discount from PhilHealth on the premiums.[4] These volume discounts, on top of the interest and fees earned on the premium loans, exceed the cost of administering the program.

Roll-out Timing and Locations

- The PhilHealth package (education and promotion, enrollment and premium loan) was pilot-tested with about 2,500 enrollees in the relatively urban areas of San Pablo, Nagcarlan, Bay, Dolores, Candelaria (now under Lucena Branch) beginning in March 2007 before being gradually expanded to over 13,600 in approximately 25 areas—also primarily urban and semi-urban—by the end of 2009. CARD intends to exceed 18,000 enrollees in more than three dozen areas by the end of 2010.

Preferred Provider Program (PPP)

In a Nutshell

- CARD provides all clients within a particular area with a "Healthy Pinoy" card that entitles them to discounts of 10 to 40 percent on primary and diagnostic healthcare services offered by local, private physicians, hospitals, laboratories and midwives. Clients are not required to use the service, but may do so at will and without CARD's direct involvement.

[3] For comparison, this $.60 weekly payment is equivalent to about 2 percent of weekly GNI ($1,890 annually) in the Philippines, as per World Bank estimates for 2008 using the Atlas method.

[4] To attain the maximum discount from PhilHealth, CARD must enroll 85 percent of groups of 4,000 and above.

CARD's Role

- CARD uses Rapid Participatory Appraisal tools to determine its clients' favored private physicians in a given area and then visits the providers to negotiate privileged pricing for CARD clients in exchange for including them on CARD's special, promoted list of "preferred providers."
- CARD gives providers "Healthy Pinoy" signage, which the providers post in their offices, and a register for documenting CARD clients who access the discounted care.
- CARD maintains the provider relationships and a simple check on prices and quality of care via quarterly visits to each provider, as well as feedback provided by clients to CARD's Account Officers.

Value Proposition

- This non-income-generating service contributes to CARD's social mission at a very low cost and may play a role in client attraction, satisfaction and retention. The program costs CARD about $3,400 to set up per area serving an average of 4,700 clients, so about $.73 per client to launch and operate during the first year; it costs about $.17 per client in each subsequent year to maintain.

Roll-out Timing and Locations

- The PPP was pilot-tested in the Bondoc peninsula, a relatively rural area, from 2007 to 2008, and was gradually expanded—also in rural and semi-rural areas—through 2009. CARD intends to cover all of Luzon and parts of Visayas and Mindanao with the PPP by the end of 2010.

Methodology

Expenses

The costing presented in this report was done using a combination of activity-based and allocation methods. Where direct, tangible costs were incurred, we used CARD's own financial records when possible, or internal staff expense reports when necessary. We emphasized the cost of operating and growing the programs rather than the upfront investment required to develop and launch them.

- In the case of the PhilHealth package—which CARD developed over several years that extended into 2007 and which involved significant and sometimes costly operational challenges due to PhilHealth's own process and systems—this emphasis on what it takes to run the program was chosen over teasing apart and analyzing what amounted to an anomalous start-up situation.[5]
- In the case of the PPP, the bulk of the operating expenses actually occur during the set-up phase, which CARD intends to maintain and grow its staff to repeat around the country for the next several years. So we focused on the cost of expanding this program according to the well-oiled system that CARD developed in 2008. We used records and statistics from the areas in which the program is already operating, coupled with CARD-wide averages of measures such as number of clients per area, to develop a per-area estimate of start-up and maintenance costs.

Revenues

Revenues (applicable only to the PhilHealth package) were drawn from a combination of CARD's financial reports, PhilHealth invoices and statements, and calculations of interest and fees.

[5] We do acknowledge that the forging and perfecting of such a partnership between an MFI and an insurance program is likely to entail challenges, unforeseen costs and significant time in just about every case. But we remain unconvinced that the financial details of CARD's particular experience in this area would be meaningful in other contexts.

Profitability

We approached this analysis from the perspective of CARD as a conglomerate (a collection of "mutually reinforcing institutions," as it refers to itself) rather than from the perspective of one or of each of the various free-standing CARD institutions involved in the PhilHealth package. For example, CARD MBA (insurance company) receives a management fee from CARD Bank and CARD NGO of 2 pesos per enrollee, which comes from the approximately 5-peso discount per enrollee granted by PhilHealth. We count only the PhilHealth discount as "revenue" and do not include the internal transfer of 2 pesos to the CARD MBA from other CARD institutions.

For the PhilHealth package, in which there are direct revenues and expenses that have changed over time as the program has developed and grown, we constructed an income statement based on actual data from 2007 through 2009, and included projections from 2010 through 2012. In assessing "profitability," we applied three levels of analysis:

a. Direct Revenues – Direct Expenses = Net Income (Loss)

b. Direct Revenues – Direct Expenses + Allocated Staff Expenses = Net Income (Loss)

c. Direct Revenues – Direct Expenses + Allocated Staff + Overhead = Net Income (Loss)

CARD management and Freedom from Hunger wanted to tease out these various levels for several reasons. The first level (a) includes the cost of staff that was added to run the service as well as all other direct, marginal costs. This is of interest because the PhilHealth package has entailed relatively low marginal costs to CARD, and both CARD and other MFIs are interested in knowing how much more they would need to budget in order to launch and run such a program. The next level (b) provides a more thorough accounting of the costs by adding on the cost of time spent by existing CARD staff in order to launch and operate the package, based on interviews with staff who estimated the time they spent at different points in the PhilHealth launch. Note that these staff—who are not devoted to the health protection services and who have been considered "paid for" by other CARD products and services—represent allocated rather than additional, marginal costs. A significant component of this expense is the amount of time that senior management spent in launching the program. Note also that because we conducted the costing exercise from 2007, as the program was already beginning to function, the management time required to set up and launch this program is underestimated—CARD leadership began building a relationship with and planning with PhilHealth as early as 2005, and initial testing of PhilHealth enrollment (without the loan) began in 2006. The third level (c) is the most conservative measure of profitability, adding on a contribution to overhead expenses based on portfolio volume. We took the percentage of CARD's portfolio represented by PhilHealth loans and applied this to CARD's actual total overhead costs for this allocation.

Cost-Benefit Analysis

A true cost-benefit analysis, though, goes beyond the crunching of financial data and profit to examine indirect and nonfinancial costs and benefits that can be quantitatively estimated and rolled into the analysis of financial gain or loss. We adopted the vantage point of the MFI itself and looked in particular for MAHP program-related impacts that might not be captured in the financials but which could ultimately enhance CARD's business bottom line. For both the PhilHealth and the PPP packages, our hypothesis was that by incorporating health protection services into its service offerings, CARD would attract and retain more clients, and would serve clients whose improved health and decreased spending on health events would translate eventually into higher savings deposits, better loan repayment and stronger microenterprises requiring larger loans.

However, identifying significant changes in such measures—let alone changes that could be reliably attributed over a short time to the MAHP services—proved predictably challenging. During the period of pilot-testing and gradual ramp-up of the health protection services from 2007 through 2009, CARD's overall institutional performance soared (NGO, Bank and RBST clients grew from about 250,000 to one million, and the portfolio volume went from $23 million to almost $80 million, while the consistently low PAR left little room for improvement), the proportion of MAHP clients remained relatively small, and CARD offered numerous value-added services—making it difficult to tease out and analyze the impact of just the MAHP one.[6] As a result, we were unable to make meaningful observations at the overall institutional level and pursued a branch-level analysis instead to see what trends and inferences might be detected.

In each of the two distinct areas in which the MAHP services were rolled out, we selected three or more branches with either the PhilHealth or PPP package, and three or more branches deemed similar in age, size, rural/urban demographic, etc. We then combed and compared this data—focusing on ratios and rates of change rather than nominal data, to normalize the inevitable differences across the branches—for any meaningful trends. Was the dropout rate lower or new-client growth rate higher in MAHP areas? Was the savings rate higher? Were there fewer late payments on business loans? Although client growth, dropout rates and other indicators fluctuated from one period to the next and from one branch to another, both within and across the MAHP and comparison areas, we were able to detect a few interesting, though inconclusive trends.

In this paper, we highlight those "additional benefits" that have been documented through this analysis as well as client-level outcomes research, staff interviews and surveys, health provider interviews, and other qualitative data—and that may well have an indirect impact on CARD's institutional bottom line.

ANALYSIS: Health Microinsurance Premium Loan Package

The Bottom Line

The following income statement (see Figure 2)—based on actual and estimated revenues and expenses for the PhilHealth package—shows CARD's experience with offering the package from 2007 through 2009. Taking into account the most conservative analysis including direct, allocated staff and overhead expenses (c), this package would have broken even in 2009 at the point at which enrollment topped approximately 13,923 clients. Instead the package, which counted 13,651 enrollees, cost CARD about $8,000 in 2009. Costs are expected to rise disproportionately in 2010 as CARD invests in an expansion of the areas in which PhilHealth loans, linkage and education are offered, and break-even is anticipated in 2012, when about 55,000 clients will be actively enrolled.

When considering only the marginal, out-of-pocket cost to CARD of offering this service, and excluding both allocated staff and overhead expenses—profitability measure (a)—the PhilHealth package carried a net cost of only $1,600 in its first year of operation (2007), earned $27,000 in 2008 and $73,000 in 2009. Figure 3 presents the number of enrolled clients required for the package to break even according to the three levels of profitability, and holding constant the expenses in each year from 2007 to 2012.

[6] CARD's value-added services include: nonformal education on health, business, financial and disaster management; a scholarship program for clients and their children; livelihoods training and linkages; life insurance with a retirement pay-out; and others.

The income ratio of this package went from -34 percent in 2007, to -2 percent in 2009. Projections show the income ratio dipping to about -5 percent in 2010, as CARD invests in expansion, and then rising again to about 2 percent by 2012, when approximately 55,000 CARD clients will be enrolled in PhilHealth using CARD's premium loan.

FIGURE 2: INCOME STATEMENT FOR CARD'S PHILHEALTH LOAN, 2007–2012

	Actual Estimates			Projections		
Revenues	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Principal repayment of PhilHealth loans	48,830	153,594	283,930	345,952	579,814	1,189,680
Interest earned on PhilHealth loans	11,719	36,862	71,119	83,029	139,155	285,523
Fees on PhilHealth loans (LRF)	732	2,304	9,650	6,919	11,596	23,794
PhilHealth discount proceeds	3,129	15,147	28,505	33,557	56,242	115,399
Total revenues	**64,411**	**207,907**	**393,204**	**469,458**	**786,807**	**1,614,395**
Expenses	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Premium payments to PhilHealth	48,830	153,594	283,930	345,952	579,814	1,189,680
Cost of funds (estimated at 8%)	3,906	12,287	22,714	27,676	46,385	95,174
Direct staff	7,499	6,716	6,266	6,751	6,751	6,489
Travel for monitoring, training, etc.	534	1,912	501	426	851	426
Branch training	290	1,170	923	1,064	1,277	1,489
Training of trainers at CMDI	3,421	-	434	1,915	1,915	1,915
Education module design	-	355	-	-	-	-
Education module printing	-	658	16	426	638	426
Supplies, computer rental	196	391	32	106	106	106
Communication	410	443	141	213	213	213
Loan-loss reserve	914	2,769	5,109	6,248	10,471	21,486
Subtotal: Direct expenses	**65,998**	**180,295**	**320,067**	**390,776**	**648,421**	**1,317,403**
Client education time allocation	12,706	33,313	40,906	52,268	86,284	106,639
Unit manager staff allocation	1,444	4,796	7,236	8,860	13,030	22,151
Management and leadership time	1,108	228	152	227	303	379
Subtotal: Allocated expenses	**15,257**	**38,337**	**48,293**	**61,356**	**99,616**	**129,169**
Allocated overhead	5,149	15,829	32,686	41,514	69,578	142,762
Subtotal: Overhead expenses	**5,149**	**15,829**	**32,686**	**41,514**	**69,578**	**142,762**
(a) Net Income (Loss)[Direct Expenses Only]	(1,588)	27,612	73,137	78,681	138,386	296,992
(b) Net Income (Loss)[Direct and Allocated Expenses]	(16,844)	(10,725)	24,844	17,325	38,770	167,823
(c) Net Income (Loss)[Direct, Allocated and Overhead]	(21,994)	(26,554)	(7,842)	(24,189)	(30,808)	25,062
Estimated clients with access (receiving education)	82,000	256,000	392,000	533,333	823,529	1,100,000

Number of clients enrolled	2,584	8,617	13,651	20,000	35,000	55,000
Enrollment ratio	3%	3%	3%	4%	4%	5%
Income ratio	-34%	-13%	-2%	-5%	-4%	2%
Portfolio-at-Risk (30 days)	3%	1%	1%	2%	2%	2%

*Exchange rate applied throughout this paper is 47 Philippine Pesos (Php) to $1 (USD)—December 2009.

**2009 data contains actual expenses through November and estimates for December. On the revenue side, enrollment estimates were made for the final quarter (Oct.–Dec.), based on the prior quarter and comparisons with the fourth quarter of previous years.

***Discounts range from about 9 to 9.7 percent, depending on enrollment and timeframe. Although CARD actually pays for PhilHealth premiums net of discount, we have opted to show the discounts as a separate line item for the sake of transparency and to highlight the value of these volume savings.

FIGURE 3: CLIENTS REQUIRED TO ACHIEVE PROFITABILITY, 2007–2012

	2007	2008	2009	2010	2011	2012
Actual or projected number of clients	2,584	8,617	13,651	20,000	35,000	55,000
Number of clients required to break even:						
(a) Direct Costs Only	2,648	7,473	11,112	16,648	28,844	44,882
Actual or projected as percentage of goal	98%	115%	123%	120%	121%	123%
(b) Direct and Allocated Costs	3,260	9,062	12,788	19,262	33,275	49,283
Actual or projected as percentage of goal	79%	95%	107%	104%	105%	112%
(c) Direct, Allocated and Overhead Costs	3,466	9,718	13,923	21,031	36,370	54,146
Actual or projected as percentage of goal	75%	89%	98%	95%	96%	102%

Revenues

PhilHealth package revenues are driven by voluntary enrollment of CARD clients, who also take the mandatory premium loan. There are three main components of revenues: interest on the premium loans paid by CARD clients, the flat fee paid by clients on the premium loan, and the volume discount provided by PhilHealth (the difference between the total individual premium payments and the amount that PhilHealth charges CARD for these).[7]

Expenses

Staff Time

Setting aside the major expense of the actual premium payments to PhilHealth (which is fully offset by client-loan repayments), and CARD's cost of funds (based on a weighted average of 8 percent), CARD's most important expense associated with the PhilHealth premium loan is staff expenses, both direct and allocated.

Direct Staff Expenses

CARD employs two permanent staff to run the PhilHealth program. One manager (who spent close to 100 percent of her time on PhilHealth in 2006) serves as the program point person and devoted about 50

[7] Under "Revenues," we opted to show both the full principal repayment made by clients to CARD, and the value of the volume discounts provided by PhilHealth. Under "Expenses," we listed the full value that CARD owes PhilHealth for the premiums, even though the amount that CARD pays is the NET of the discounts provided. We do this to provide a transparent picture of the value of the volume discounts, which provide a small operating margin to CARD for this product.

percent of her time in 2007, 30 percent in 2008 and 15 percent in 2009; CARD estimates that she will spend about 25 percent of her time on this program in the coming three years, as the program expands much more broadly. (The remainder of this person's time goes toward other health-related activities, including the PPP also described in this paper.) The second staff person is devoted 100 percent to PhilHealth, working closely with the manager. Both of these staff members represent new, marginal costs to CARD to offer this service. Direct staff costs—which remain relatively fixed regardless of enrollment—run $6,000–$7,000 per year.

Allocated Staff Expenses

Existing CARD field staff members also play a role on the PhilHealth loan package. CARD credit officers devote a portion of their time to facilitating training sessions for groups of clients on health Microinsurance and PhilHealth in particular. We estimate that all clients in the units in which the package is being promoted for the first time receive eight 15-minute education sessions during the first year and that credit officers spend about one-half that time providing refresher briefings to the same clients in the years that follow. Unit managers[8] play a role in verifying and entering data from PhilHealth enrollment forms; CARD estimates that each Unit Manager spends about two days per year to fulfill these activities. Finally, CARD senior management participates in occasional meetings with PhilHealth leadership and with lower-level CARD staff to monitor and improve the program. Allocated staff costs have gone from $15,000 to over $48,000 annually and will continue to rise as the program expands and more people are trained and involved in administration.

Training

A second major expense category is training. In order to both promote the program and also educate clients on health insurance, the enrollment process, benefits, and what to expect (and not expect), CARD developed a series of interactive education sessions that have been integrated into the MFI's *Credit with Education* program. Expenses include: the cost of developing the education module; printing the session guides and images for the decentralized managers who train the field staff who lead the sessions with clients in the field; and the cost of staff travel and participation in a Training of Trainers to equip them with the knowledge and tools to "cascade" the education sessions to the field staff in their region.

In the direct expense category, we did not include allocations of time spent by credit officers in conducting the training sessions with clients because this constitutes an integral part of their jobs as *Credit with Education* field agents, paid for through the credit and other products that they simultaneously oversee; these are found instead in the allocated staff costs included in profitability measures (b) and (c), as described above.

Total direct training costs for the PhilHealth package were about $4,000 per year in 2007 and 2008. Costs dropped to $1,900 in 2009 after almost all members in the target areas had received the education sessions, and are expected to hover at about $4,000 annually in the coming years as the program gradually expands around the country and new staff members are trained in cyclical batches.

Other Direct Expenses

We incorporated CARD's standard 2 percent loan-loss provision, along with reported and expected communications and supplies expenses.

8 A unit is roughly equivalent to a branch, although some branches have more than one unit; the number of units offering the PhiHealth loan was 41 in 2007, 128 in 2008 and 196 in 2009.

A relatively modest expense that is not reflected here is the cost to CARD of making up for enrollment or benefit errors that have occasionally occurred. Early in the program, for example, a few CARD clients who had enrolled in PhilHealth and were current on their PhilHealth loan payments to CARD could not be found in PhilHealth's system and were duly refused medical payment or reimbursement. In these rare instances, CARD covered the expense in order to preserve clients' confidence and provide them with fair service. Again, CARD management views these costs as extremely low, and we were unable to incorporate details of these expenses in the profitability analysis.

Overhead

Finally, as presented under Methodology, overhead has been allocated based on the ratio of PhilHealth loan portfolio to overall CARD Bank and NGO loan portfolios. As such, this will continue to rise as the program grows.

Additional Benefits

While the profitability analysis shows a clear financial incentive for CARD to offer this particular service package, we also sought to identify indirect benefits (or costs) that would translate into an eventual financial gain (or loss) for the MFI. We examined several basic measures in branches in which the PhilHealth package was offered and similar branches in which the package was not (control branches were not randomly selected). The changing landscape of branches (merging of some, transformation of NGO to Bank, opening of new, etc.) and the rapid growth of both the health protection services and CARD's outreach in general posed challenges for detecting meaningful trends or correlations, and will likely continue to present a barrier to such analysis in the future.

> *"Membership to CARD bank in this unit has increased because of PhilHealth. CARD is the only MFI in the Philippines offering this kind of benefit."*
>
> –CARD branch staff member

Client Growth and Retention

CARD staff had repeatedly observed that client growth and retention appeared higher in branches in which PhilHealth was available. Our analysis of the underlying data could not confirm (or deny) these assertions. However, CARD management also made the intriguing observation that the PhilHealth loan has helped turn numerous clients who had previously only been "savers" into (profit-making) borrowers, because many clients have for the first time taken out a loan for PhilHealth coverage after years of only saving with CARD, and this could be an entry to regular microenterprise borrowing with CARD. The data did bear out this assertion among NGO branches with moderate statistical strength, as shown in Figure 3 (the percentage of savers with "savings only" was significantly lower in NGO branches offering PhilHealth than in the NGO control branches)—but this result should be viewed simply as a possible indication of a connection between the PhilHealth package and increased proportion of borrowers. Moreover, whether or not those clients who had formerly only saved will go on to borrow microenterprise loans remains to be seen.

FIGURE 4: STATISTICAL CORRELATIONS BETWEEN BRANCH-LEVEL MEASURES AND THE OFFER OF PHILHEALTH PACKAGE (BASED ON 2009 DATA)

Test Statistic	Hypothesis	PhilHealth—NGO	PhilHealth—all branches combined
Growth in number of active members	Higher in branches with intervention	-	-
Percentage growth in active members	Higher in branches with intervention	-	-
Dropout rate in November 2009	Lower in branches with intervention	-	-
	Higher in branches with intervention	-	-
Growth in savings deposits	Higher in branches with intervention	-	-
Growth in loan disbursements	Higher in branches with intervention	-	-
Total disbursements, December 2007 to November 2009	Higher in branches with intervention	**	-
Growth in loan portfolio	Higher in branches with intervention	-	-
Total loan portfolio in November 2009	Higher in branches with intervention	***	***
Average loan size in November 2009	Higher in branches with intervention	-	*
Growth in average loan size	Higher in branches with intervention	-	-
PAR>1 amount in November 2009	Lower in branches with intervention	-	-
PAR>1 rate in November 2009	Lower in branches with intervention	-	-
Total savings deposits in November 2009	Higher in branches with intervention	**	**
	Lower in branches with intervention	-	-
Growth in total savings deposits	Higher in branches with intervention	-	-
Growth in savings-only clients	High in branches with intervention	-	-
Percentage savers with savings only in November 2009	Higher in branches with intervention	-	-
	Lower in branches with intervention	**	-

Key:
- \- No statistical difference
- * Significant at the 10% level (slight statistical difference)
- ** Significant at the 5% level (moderate statistical difference)
- *** Significant at the 1% level (most significant result)

Notes:

(i) Statistics for growth are in all cases calculated from June 2007 to November 2009. Since two branches did not have data recorded for June 2007, they were excluded from the tests for growth variables.

(ii) Significance tests cannot be performed for the PhilHealth Bank branches because there is only one intervention branch and one comparison branch.

For the sake of argument, we explored what the financial impact would be if just 1 percent of actual PhilHealth enrollees at CARD came from "saver only" status to take a PhilHealth loan and then went on to also borrow for their microenterprises. Figure 4 presents the results. Knowing, based on historical data, that the average CARD borrower brings in about $43 in revenues per year for CARD, we estimate that the marginal revenues of 1 percent of PhilHealth clients would have been nearly $6,000 in 2009, and would amount to almost $24,000 by 2012. While this does not significantly change the break-even point of the product, it does contribute to overall earnings for CARD from offering the PhilHealth package.

FIGURE 5: PHILHEALTH PACKAGE: THEORETICAL VALUE OF "NEW" BORROWERS AND RESULTING NET INCOME

	2007	2008	2009	2010	2011	2012
Number of PhilHealth enrollees	2,584	8,617	13,651	20,000	35,000	55,000
1% of PhilHealth enrollees ("new" borrowers)	26	86	137	200	350	550
Annual "value" of new borrowers	1,123	3,744	5,931	8,690	15,208	23,898
Revised Net Income (a) Direct Expenses Only	(465)	31,356	79,069	87,371	153,594	320,890
Revised Net Income (b) Direct and Allocated	(15,722)	(6,981)	30,775	26,015	53,977	191,721
Revised Net Income (c) Direct, Allocated, Overhead	(20,871)	(22,810)	(1,911)	(15,499)	(15,600)	48,959

Institutional Learning and Staff Satisfaction

Another possible benefit to CARD of offering the PhilHealth package has been institutional and staff learning about health Microinsurance. CARD intends to offer health Microinsurance directly to clients sometime in the future, and the education that CARD has obtained "at the knee" of PhilHealth, so to speak, has had an incalculable value for CARD's future health insurance business. Moreover, those CARD staff involved in educating clients about and administering PhilHealth enrollment indicated particular satisfaction with their work through staff surveys—they said they feel confident of their knowledge and proud to be able to help their clients as well as friends and family by sharing important information about this high-profile national program.

> *"Members (with PhilHealth) tell us that they are treated better by the hospitals and that they are relieved from the need to make upfront deposits before they can obtain services."*
>
> —CARD staff member

An MFI now better equipped to provide health Microinsurance on its own (thereby potentially earning significant profit down the road) and boasting staff that are well-informed, self-confident, and satisfied in their jobs is clearly reaping institutional benefits from its offer of the PhilHealth package. CARD's management has reiterated that monumental anecdotal evidence gleaned through their intensive monitoring and client interaction has convinced them that the PhilHealth Program—which is widely heralded by clients in interviews—is a definite boon to CARD clients and the MFI, and it intends to continue expanding the program. CARD plans to have approximately 20,000 enrollees by the end of 2010, 35,000 by 2011 and 55,000 by 2012.

ANALYSIS: Linkages with Health Providers

The Bottom Line

As the expense statement below shows (see Figure 2), this non-income-generating program cost CARD approximately $17,000 to operate in 2008 and $63,000 in 2009; large-scale expansion of the program in 2010 will amount to about $400,000 in expected costs in 2010. Looking at these costs on a per-client basis, we determined that it costs CARD about $.73 per client to launch a PPP in a new area, and about $.17 per client annually to maintain the provider network. Considering that provider discounts range from 10 to 40 percent and that a typical provider fee is $5, as presented below, a savings of $.50 (10 percent of $5) on just

one provider visit by a client or her family member approaches the per-client cost to CARD of setting up the network and significantly exceeds the annual per-client maintenance cost to CARD.

This ratio of CARD investment to client value could be very appealing to third-party donors wishing to achieve health impacts in partnership with CARD, but CARD views it as a cost-effective method of contributing to the MFI's social goals and a potential contribution to significant client growth and retention. Therefore the MFI covers this service out of its own earnings as a regular management expense.

CARD plans to rapidly expand the PPP to serve all of its branches nationwide over the coming years. By the end of 2010, all of Luzon and parts of Visayas and Mindanao will be offering this service.

FIGURE 6: EXPENSE STATEMENT FOR CARD'S PREFERRED PROVIDER PROGRAM, 2008-2009*

Expenses	Per Area		Actual Estimates	
	$	PHP	2008	2009
Start-up costs (3 MONTHS)				
Dedicated staff time for creating network	1,961	92,187	7,846	31,383
Allocated staff time for creating network	543	25,512	2,171	8,685
Materials cost for creating network	293	13,791	1,174	4,695
Transportation	620	29,139	2,480	9,920
Communication	10	450	38	153
Paper, supplies, etc.	4	200	17	68
TOTAL PPP start-up costs	**3,431**	**161,279**	13,726	54,903
Per member cost	**0.73**	**34**	—	—
Annual maintenance costs				
Dedicated staff time	317	14,899	1,268	3,170
Allocated staff time	362	17,008	1,447	3,619
Materials	85	3,996	340	850
Transportation	45	2,108	179	449
Communications	3	150	—	—
Paper, supplies, etc.	—	—	—	—
TOTAL annual maintenance costs	**812**	**38,161**	3,235	8,087
Per member cost	**0.17**	**8**	.17	.11
TOTAL EXPENSES			16,961	62,990
Net Benefit / (Cost)			(16,961)	(62,990)

No direct revenues

Expenses

The program entails relatively low fixed and almost no marginal costs (per additional client) to operate within a given region. During the start-up phase in a new area, CARD staff has legwork to do in identifying and contracting with providers, but after that the program literally runs itself, and tens of thousands of clients

within a moderate radius of the providers can continue to be served and to benefit over a long period. We broke down the expense analysis into two categories: the cost of starting up in a new area (to help CARD and potentially other replicating MFIs to estimate the cost of expansion) and the cost of maintaining the PPP in the years subsequent to the launch.

Start-up Expenses

In all, CARD's experience has been to spend about $3,400 to set up the PPP in a new area, serving an average of 4,700 clients, for an approximate per-client set-up expense of $.73, up to the three-month period necessary.

As with the PhilHealth package, the primary expenses associated with this program are direct and allocated staff expenses. One full-time staff person (CARD hires nurses for credibility with healthcare providers) manages the start-up process for up to three months per area, with an upper limit of about 28 days per area in support and guidance from the MAHP Manager or another management-level staff person with experience in PPP (for example, CARD will promote nurses with PPP experience to train and guide new nurses as the program expands). Start-up activities include identifying, contacting, visiting, negotiating with and establishing partnerships with healthcare providers. CARD's Account Officers (responsible for all business loan, deposit and nonformal education for clients in their portfolio) spend up to two minutes per client to create a green PPP card, and their supervisors, the Unit Managers, spend as much as one minute per card to certify and sign-off on them.

Transportation costs account for the next-largest expense in starting up the PPP in a new area. Each provider is typically visited by CARD staff an average of three times before signing a Memorandum of Understanding. Because the bulk of CARD's MAHP team transportation expenses in 2008 were for the PPP (rather than PhilHealth), we took total MAHP transportation in 2008 and divided by five, accounting for the four PPP areas started up during that year, plus the travel for PhilHealth-related activities estimated as equivalent to about one PPP area.

Materials expenses are the next most important start-up expense. Materials are the client cards (at 2.5 pesos, or $.05 per client, good for six years) and the provider logbooks (at 50 pesos or about $1 per provider, usable for about two years). We took the average number of clients per CARD area (4,700) and the average number of contracted PPP providers per town (6.875) multiplied by the average number of towns per area (about 5), to derive these per-area expenses. Finally, communication and general office supplies are estimated to be about $14 per new area.

Maintenance Expenses

CARD spends approximately $800 per area (serving 4,700 clients on average) to maintain the PPP, for a total annual cost of about $.17 per client.

The dedicated PPP staff (typically the nurse originally responsible for setting up the network in the area) devote about one day per month to provide follow-up and monitoring visits, while a MAHP Manager devotes about one day per quarter to supporting activities and monitoring per area. The Account Officers spend about one minute per client card annually to make updates (as in number of family members), and Unit Managers spend less than one minute to verify and sign-off (we rounded up to one minute).

For annual materials expense, we used the biannual replacement of provider logbooks and assumed 10 percent of the 4,700 clients would be new or otherwise require replacement cards. We based transportation and communications costs on actual per-area maintenance expenses in 2009.

Note that we did not include the cost of Account Officers' time in describing and promoting the PPP to clients because it is minimal, viewed as a normal part of their time and jobs, and does not represent any significant opportunity cost to CARD.

Additional Benefits

Client Growth and Retention

As with the PhilHealth package, CARD field staff and management reported that branches experienced enhanced client growth, satisfaction and retention as a result of this service. Similarly, client-level research showed that CARD's array of nonfinancial services—of which the PPP is one—were appreciated and cited by clients as reasons they joined and stayed with CARD. Our analysis of the underlying data could not confirm that this was the case (see Figure 7). In fact, drop-out appeared notably higher in branches offering the PPP; information about exogenous reasons for some of the trends observed and presented in Figure 7 was not readily available, and this bears further analysis.

FIGURE 7: STATISTICAL CORRELATIONS BETWEEN BRANCH-LEVEL MEASURES AND THE OFFER OF THE PREFERRED PROVIDER PROGRAM (BASED ON 2009 DATA)

Test statistic	Hypothesis	PPP—Bank	PPP—NGO	PPP—all branches combined
Growth in number of active members	Higher in branches with intervention	-	-	-
Percentage growth in active members	Higher in branches with intervention	-	-	-
Dropout rate in November 2009	Lower in branches with intervention	-	-	-
	Higher in branches with intervention	-	***	**
Growth in savings deposits	Higher in branches with intervention	-	-	-
Growth in loan disbursements	Higher in branches with intervention	-	-	-
Total disbursements, December 2007 to November 2009	Higher in branches with intervention	-	*	-
Growth in loan portfolio	Higher in branches with intervention	-	-	-
Total loan portfolio in November 2009	Higher in branches with intervention	-	-	-
Average loan size in November 2009	Higher in branches with intervention	***	-	-
Growth in average loan size	Higher in branches with intervention	-	-	-
PAR>1 amount in November 2009	Lower in branches with intervention	**	-	-
PAR>1 rate in November 2009	Lower in branches with intervention	**	-	-
Total savings deposits in November 2009	Higher in branches with intervention	-	-	-
	Lower in branches with intervention	**	-	*
Growth in total savings deposits	Higher in branches with intervention	-	*	-

Growth in savings-only clients	High in branches with intervention	-	(not tested)	*
Percentage savers with savings only in November 2009	Higher in branches with intervention	-	-	-
	Lower in branches with intervention	***	-	-

Key:
- No statistical difference
* Significant at the 10% level (slight statistical difference)
** Significant at the 5% level (moderate statistical difference)
*** Significant at the 1% level (most significant result)

Nevertheless, once again we performed a rough analysis of the theoretical impact to CARD if the PPP did in fact bring about even a 1 percent growth or retention of clients. Based on CARD's average annual earnings per borrower of $43, such minimal growth or retention of clients would lead to revenues that cover about one-half the annual cost of providing the PPP (see Figure 8). If CARD continues to track growth and retention in the PPP and comparable areas over a longer period or can otherwise study the reasons that clients join or stay with CARD to ascertain whether the PPP plays a significant role, the MFI may be able to concretize and quantify the true net income or loss from this service.

> *"My child has a heart problem and must have one injection each month to stay alive. With the discount (for the provider network) I am able to save money each time."*
>
> —Maria Linda Aguilar, CARD member

FIGURE 8: PREFERRED PROVIDER PROGRAM: THEORETICAL VALUE OF NEW OR RETAINED CLIENTS AND RESULTING NET LOSS

	2008	2009	2010*
PPP net income (Loss) $	(16,974)	(63,022)	(397,912)
Estimated number clients in PPP areas	18,800	75,200	479,400
Theoretical 1% client growth or retention due to PPP	188	752	4,794
Value of new or retained clients (annual) $	**8,169**	**32,675**	**208,302**
Revised PPP net income (Loss) $	(8,805)	(30,348)	(189,610)

*Projected

Staff Satisfaction and Health

In surveys, CARD staff members underscored their satisfaction with seeing the impact of the PPP on clients. One branch staff person pointed out the importance of market research, though, saying: "You need to conduct a survey before implementation because some places are not that much in need, like progressive areas. But it is very applicable here because we are far from the city." Staff members also enjoy PPP discounts themselves, which enhances their satisfaction with the service, as well as their knowledge and ability to convey information to clients about how it works. One staff person stated, "I learned that before, people were not very health conscious, but after presenting this program, they are healthier and also the account officers are more health conscious—we use the PPP discount, too." The potential impacts of more proactive, healthier staff on CARD or other MFIs would be valuable to examine.

> *"I have increased self-confidence because this is a new innovation. You feel important because very few are doing this type of job with microfinance plus health…..It can empower the community to take charge of its health."*
>
> —CARD staff when asked about the impacts of CARD's health protection services

Client-level Value

A comparison of the per-client cost to CARD of operating this service with the value to one client in saved healthcare expenses shows significant value creation. With a 10 percent discount on a doctor's visit costing a typical amount of $5, a client would save $.50—already more than double the cost to CARD of maintaining the program, after a single visit at the lowest discount level. Considering that research conducted at CARD as part of the MAHP initiative showed that 23 percent of clients surveyed[10] had at some point used proceeds from their CARD business loan to pay for health expenses, both the reduction in health expenses and potentially prompter seeking of health care (leading to fewer complications and thus lower expense and time away from work) brought about by the PPP may well translate into fewer diversions of business funds, healthier microenterprises, better loan repayment and higher loan sizes and savings deposits.

Health Provider and Health Sector Value

Finally, although its connection to CARD's business bottom line is more tenuous, we believe it is important to point out that the participating health providers themselves are positive about this service. In interviews, PPP providers stated that their clientele had expanded as a result and that they would continue participating in the service as long as they could. In a country experiencing an extreme shortage of healthcare professionals—particularly, but not only, in rural areas—it is notable that such a low-cost program can help boost the business of local doctors and exert positive pressure on them to remain in smaller towns. Ultimately the availability and accessibility of health care to CARD clients is likely to reinforce CARD's ability to flourish and continue offering microfinance in more rural, isolated communities.

> *"My total number of patients has increased since partnering with CARD."*
>
> —Dr. Reynolds, Hospital, Mulaney, Philippines

Conclusion

Summary

CARD and Freedom from Hunger set out to learn whether an MFI could develop and offer health-related services that would enhance its microfinance offerings, have a positive social impact on clients, and ultimately enhance the financial bottom line of the MFI itself. CARD tested two packages—the PhilHealth package, entailing a linkage to government health Microinsurance with a premium loan to spread out the payments and education to increase understanding and satisfaction, and a Preferred Provider Program, offering clients special access to discounts on health care from local health providers.

[10] This is from a survey of CARD clients (N=40) in the PhilHealth pilot-test area conducted in 2009.
[11] See Microfinance and Health Protection Research Summary: CARD. Freedom from Hunger. 2010.

We found that the PhilHealth package could be offered not only sustainably but eventually also profitably by CARD, and that the PPP can achieve valuable social and marketing aims at a very low per-client cost. Both packages have resulted in positive health and financial benefits for CARD clients,[11] and there is anecdotal evidence that they have led to enhanced client growth, satisfaction and retention that could significantly enhance the scale and performance of CARD's microenterprise loan portfolio. Meanwhile, the services have contributed to institutional learning about health insurance and clients' health-related needs and demands, as well as to the satisfaction and morale of CARD staff who feel proud to be undertaking such meaningful work. CARD leadership is satisfied with these two health protection packages and intends to scale up both of them network- and nation-wide over the coming few years. Combined, the PhilHealth and PPP service packages will offer CARD clients comprehensive and affordable health coverage, from health consumer education and discount primary care to family-wide hospitalization insurance paid for in tiny weekly sums.

We feel that these experiences and findings comprise a significant contribution to the microfinance sector regarding the viability of using microfinance as a platform for the extension of health services. Our analysis concludes that certain services can be offered on a financially self-sustaining basis, while others can be low-cost investments in MFI reputation, competitive position and social mission. In talking about organizational strategy and how it relates to CARD's work on integrating health protection, the MFI's leader Dr. Aristotle Alip said that whenever the day-to-day financial details cause him to drift, returning to the field to talk directly with clients always helps him see the path clearly. He went on to say that "The MAHP program touches the core of our clients' needs, and therefore it is absolutely core to what we do at CARD. It is an investment that yields long-term benefits for our organization and its members."

Lifetime Value of a Client

Although it was not feasible to prove a correlation between increased client growth and/or retention and the availability of MAHP services, anecdotal evidence from CARD clients and staff lead us to believe that the additional value of these services may well contribute to client attraction and retention. The value to CARD of merely a 1 percent increase in client attraction or retention as a result of the MAHP services described in this paper could considerably exceed the cost of their development and maintenance. CARD's average loan size is $145 (average of CARD NGO and CARD Bank loan sizes in 2009); average interest earned on each loan is about $43 (based on 30 percent flat interest rate and six-month terms). CARD was serving about one million clients at the end of 2009, and marginal costs per client are low since (up to a certain limit per branch) they are served in groups. If we assume, based on conservative historical data, that the average client stays with CARD for 3.1 years,[12] then each new member attracted is worth about $136 in "lifetime value." Thus, the value of just a 1 percent increase in client attraction or retention in 2009 would have been worth more than $1.4 million to CARD in additional microenterprise loan interest revenues. Comparing this financial gain to the combined net price tag of the PhilHealth and PPP packages developed and delivered between 2007 and 2009 of $534,000,[13] and taking into account CARD's operating expense-to-loan portfolio ratio of about 38 percent, the provision of health-related services by this MFI appears to be a bargain.

[12] This is based on CARD Bank data, which was readily available and likely understates the longevity of the average CARD client. The NGO has been around longer and operates in more rural areas, and retention at the NGO is estimated by a cross-section of stafff to be about 2.8 years.

[13] This is the net cost of the PhilHealth package over the three years from 2007 through 2009, plus the net cost of the PPP in 2008 and 2009.

Further Innovation and Research

We hope that the data provided in this paper will serve to inform and inspire other MFIs to explore practical and cost-effective ways of addressing the critical link between poverty and ill health—not only with the aim of better achieving their social missions and meeting the criteria of many social investors, but also with the growing conviction that by addressing this need and improving the health of their clients, they can in turn enhance the health of their own income statements.

Additional research is needed on the costs and benefits of providing such integrated microfinance and health services. As CARD and the other MAHP MFIs move beyond the pilot phase and work to scale up their health protection services, and as other MFIs implement and scale up such services, we hope to conduct and read further research on the value that these complementary services carry for the MFIs and their achievement of financial sustainability.