Kashf Foundation Focus Notes Series
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Getting Health Insurance Right for Low-Income Households: The KASHF Experience in Pakistan

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Access to health-care is limited for low-income households across the world, this Focus Note documents the successful experience of Kashf Foundation in enabling access to over 1 million low-income individuals to micro-health insurance.

ACCESS TO HEALTH-CARE

The World Health Organization enshrines 'the right to the highest attainable standard of health' as a universal right for all. The attainment of this right requires a set of social criteria that is conducive to the health of all people, including foremost access to health-services, followed by safe working conditions, adequate housing and access to nutritious foods.

Access to health-care itself is determined by the following key factors (1) the availability of health services, (2) the adequacy of the supply of services, (3) the opportunity to obtain health care services, and (4) a person's geographic proximity to available services.[i] ***In developing countries the supply of health services is not equitable or widespread; a majority of high quality health-care services are concentrated in the private health care sector which is often prohibitively expensive for low-income households to access.*** There is the added factor of geographic proximity as most high quality private health-care providers tend to establish themselves in more uptown and posh localities which are more accessible to high-income households who are either geographically nearer to these health-care providers and/or have the means, with respect to mobility, to access these providers.

These factors show that just because health care facilities exist in a particular region it does not necessarily mean that they are readily accessible to low-income households. ***Not surprisingly, the poor need these services the most since poverty is a major cause of ill health and the largest barrier to accessing health care when needed[ii].***

Low-income households fare worse than higher income households as the poor cannot afford to purchase items needed for good health such as sufficient quantities of quality food and preventative health care such as vaccinations. This is further exacerbated by other factors related to poverty, such as lack of hygiene and information on practices that can promote health. To cater to the health-care needs of low-income households well-designed health insurance schemes - which ensure quality, access, convenience, and add on components of improved well-being via health camps and awareness sessions, provide the most suitable solution.

The main challenges in providing health insurance to low-income households, especially in the context of Pakistan, include the lack of awareness among low-income individuals, lack of willing/able insurance providers interesting in moving their client base downstream, prohibitively expensive insurance premiums, limited number of low-cost hospitals being able to qualify for empanelment with insurance companies, and upfront costs of premiums. ***Kashf Foundation through an innovative micro-health insurance program has been able to address most of these challenges to be able to successfully provide health insurance services to 1,275,844 low-income individuals at June 2017 closing (active members).***

KASHF'S FORAY INTO INSURANCE

Kashf has been the pioneer in bringing insurance to low-income households; in 2002 Kashf was the first microfinance institution to offer a credit for life insurance cover to its clients. The rationale for introducing the product was simple enough, but Kashf had to undertake significant canvassing with insurance companies before a mutual agreement on product

features and price could be reached. Kashf's efforts paid off and the first of its kind credit for life insurance was introduced by Kashf Foundation. ***This product not only had positive spill-overs for clients but also had a large-scale demonstration effect across the microfinance sector and today the credit-for-life product has become an industry practice.***

Kashf's experiment with health-insurance has however, taken a longer time to 'get right'. Kashf realized the need for health related products/services for its client as multiple client feedback solicitation channels from the field consistently reported that clients were unable to access healthcare services. ***Research findings showed that clients often utilized earnings from their micro-businesses towards meeting healthcare expenses which translated into a financial burden on the clients in terms of straining their repayment capacity but also stunted the growth of their micro-businesses and/or low productivity.***

KASHF HEALTH INSURANCE ROUND 1

Kashf offered its first iteration of the health-insurance program in 2007 when health insurance for low-income households was virtually non-existent. Kashf's research with clients had shown a list of features balancing access, coverage, and cost which Kashf tried to incorporate into product features during discussions with insurance companies. In 2007, in collaboration with the First Micro Insurance Company Kashf's first health-insurance product was launched with the following features: (1) coverage for the client and her spouse, (2) upfront premium, (3) hospitalization coverage upto PKR 25,000. While this list of features was not as exhaustive as Kashf had originally intended, since this was the first real foray into this segment by insurance companies in Pakistan there were reservations on the end of the insurance company on more exhaustive features which were agreed to be added on to the product in later years after getting a feel of the customers. The product was piloted for a year, and had limited success. The end of pilot evaluation showed five major learnings:

1. Clients wanted a product that covered their children as they often prioritized their children's health-care needs over their own;
2. Clients were unhappy with the up-front premium and viewed it as a deduction from their loan amount;
3. Maternity related hospitalization was the most frequent cause of hospitalization which was not covered in the health insurance which caused dissatisfaction;
4. There were significant exclusions for pre-existing conditions which the clients did not understand and thereby found it hard to understand the terms and conditions of the product;
5. The claim process took longer than expected as clients struggled with getting complicated forms/documentation filled out.

Kashf's Health Insurance Program- Version 1.0

The first iteration had the following product features:

- Coverage for the client and her spouse
- Upfront premium
- Hospitalization coverage upto PKR 25,000

After the end of pilot the product was discontinued as client advice and feedback could not be accommodated in product features at that time.

HEALTH INSURANCE RE-PLUG: ROUND 2

A re-plug was undertaken in 2013 when Kashf re-started its efforts towards developing and offering a more effective health insurance product to its clients. This included a reassessment of client needs and preferences through semi-structured interviews, ranking exercises, and focus group discussions. Four insurance companies were approached for product development, and Kashf found a strategic partner in Jubilee Insurance which had the vision and commitment to getting the product, delivery mechanisms and price right for Kashf clients. Moreover, Kashf Foundation also started approaching a variety of smaller private hospitals to educate/inform them of requirements and policies for becoming panel hospitals with the insurance company to increase the options for clients for cash-less access to health-care.

In 2014, the product was piloted across 18 Kashf branches. The pilot was challenging on a number

of fronts; (1) marketing the product as clients had never accessed a similar product and no other provider was offering it, (2) the limited number of smaller private hospitals mapped onto the insurance company's panel network especially in the smaller towns and cities which constrained the ability to go cashless in these areas, (3) the upfront payment of the premium, and (4) delays associated with providing health insurance cards to clients which were dispatched from the insurance company and received by Kashf's head office and then dispatched to branches which finally gave them to the clients. To address the product related issues, i.e. upfront premiums and delays in receiving cards Kashf initiated discussions with the insurance company to explore possible solutions.

To address the client education and marketing issue, Kashf has invested significantly in the capacity building of staff and clients. In 2015 2,600 staff members were part of trainings and refreshers on health insurance, which was supplemented by further refreshers in 2017 with over 1,750 staff members. Client education and awareness raising has been undertaken via innovative and interactive means such as social theatre performances and inclusion of an insurance module in financial education trainings with clients – 100 theatre performances on the theme of health insurance attended by over 10,000 clients have been undertaken and over 177,000 women have been trained on health insurance via the financial education module.

To address the issue of panel hospitals, Kashf staff undertook mobilization of owners/ administration of smaller private hospitals on the benefits on empanelment and providing guidelines for capacity building to be eligible for empanelment which has led to 196 panel hospitals being available for Kashf clients, which was 85 at the start of the program.

To speed up the claim processing, a doctor has been hired at the Head Office who re-verifies all client health claims before they are dispatched to the insurance company to reduce errors and linked inefficiencies. The client service cell has also been set up to address queries from clients regarding delays in claim processing.

Even as the product is offered across Kashf's branches significant time and effort is being dedicated to the smooth upkeep of the product including centrally delivered need based refresher trainings and time spent by ***Business Development Officers on (1) guiding clients on coverage, (2) advocating with medical practitioners on behalf of the clients, (3) building rapport and relationship with panel hospitals, and (4) managing claim processing***. According to a recent time-mapping exercise undertaken field staff on average spend about 5-10% of their productive time on claims handling for the product.

Kashf Health Insurance Version 2.0 - Key Product Features		
	Pilot	**Roll-Out**
Coverage	Family Coverage*	Family Coverage*
Premium Payment	Upfront Payment	Monthly Payment
Premium	Two plans; Plan A with maternity coverage costs PKR 1,750 and Plan B without maternity coverage costs PKR 1,150	Two plans; Plan A with maternity coverage costs PKR 1,850 and Plan B without maternity coverage costs PKR 1,200
Per person coverage	PKR 30,000	PKR 30,000
Insurance Card Receipt Time	30-45 working days - Centralized cards	Instant – Decentralized letter issued by branches
Existing Pre-Condition Exclusions	None	None
Maternity Coverage	Yes	Yes
Newborn Coverage	Yes	Yes
Work Compensation	Daily pay-out for family in case of hospitalization of major bread-earner.	Daily pay-out for family in case of hospitalization of major bread-earner.
Health Camps	Provided periodically over the entire Kashf network	Provided periodically over the entire Kashf network

PRODUCT OUTCOMES

At June 2017 closing over 1 million individuals were covered in the micro health-insurance. The product has turned into a competitive advantage for Kashf over other competitors as shown by recent Customer Satisfaction Surveys (July 2017). Cumulatively, 33,119 claims (out of which 58% have been cashless) amounting to over PKR 548 million (out of which PKR 294 million are cashless) have been paid out.

58% of the claims have been cashless as a proportion of numbers while 54% of the claims have been cashless as a percentage of the amount paid

An analysis of the health insurance claims processed in 2016-2017 has shown that more than 69% of the number of claims and 70% of the total claims value was from women. The average claim amount for females was PKR 16,843 while that for males was PKR 15,607. Moreover, PKR 1,480,693 were given as work-compensation to 1,882 families from July 2015 – June 2016 with an average pay-out of over PKR 787 per family.

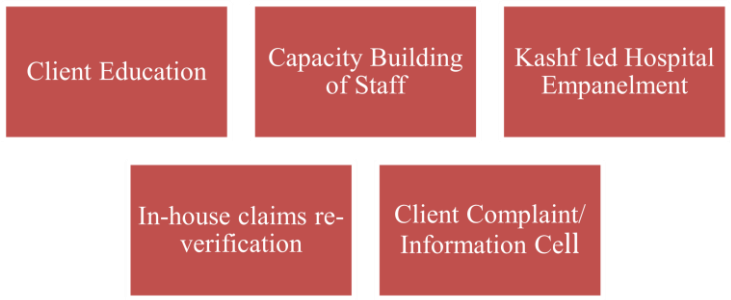
These are promising trends and further research has shown that for most women this was the first time they had accessed formal health-care, which highlights the fact that often women under value their own health, and it was only after the health insurance cover that they addressed some of their primary health care issues. ***Micro-health insurance has thus provided these women access to high quality medical services, which will reduce both maternal and infant mortality in Kashf's cohort***.

KEY LESSONS LEARNT

Using client feedback and behavior as the driving force, Kashf has been able to strike the balance between access, coverage and price which has led to the success of the product. The key lessons over the course of this process have been as follows:

1. Keep the clients at the center of product development;
2. Invest time and money in client education about insurance and create a powerful and cogent marketing pitch;
3. Find a partner that is aligned on the product objectives across management and implementation tiers;
4. Innovation is key, think outside the box on product features and delivery mechanisms.
5. Negotiate the best price for clients and develop ways in which the burden can be divided over the insurance term such as using monthly or quarterly installments for insurance premium payment.

Kashf's Institutional Investment into Making the Health-Insurance Work



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[i] Gulliford M, Figueroa-Munoz J, Morgan M, Hughes D, Gibson B, Beech R, Hudson M. (2001) J Health Serv Res Policy. 2002 Jul; 7(3):186-8 "What does 'access to health care' mean?"
[ii] World Bank: The Link between Poverty and Health. http://www.worldbank.org/en/topic/health/brief/poverty-health
* Client and her spouse along with all children under the age of 18 are covered, unmarried daughters over the age of 18 are also covered.