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Utilization of Health Microinsurance: Evidence from Focus Group Discussions

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Preface

The Centre for Research in Economics and Business (CREB) was established in 2007 to conduct policy-oriented research with a rigorous academic perspective on key development issues facing Pakistan. In addition, CREB (i) facilitates and coordinates research by faculty at the Lahore School of Economics, (ii) hosts visiting international scholars undertaking research on Pakistan, and (iii) administers the Lahore School's postgraduate program leading to the MPhil and PhD.

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It is hoped that these papers will promote discussion on the subject and contribute to a better understanding of economic and business processes and development issues in Pakistan. Comments and feedback on these papers are welcome.

Acknowledgments

We are extremely grateful to Kashf Foundation for their indispensable support and assistance in carrying out this research. The research team is also thankful to Dr. Shahid Amjad Chaudhary, Rector, Lahore School of Economics and Dr. Naved Hamid, Director, Centre for Research in Economics and Business for facilitating our research endeavors.

Abstract

This paper examines the social and economic effects of health microinsurance and explores potential channels through which usage can be increased using insights obtained from in-depth focus group discussions (FGD). Our main findings were as follows: (i) women are the most active users of the program with a major focus on seeking health care for maternal and gynecological conditions; (ii) The program can promote client retention, thereby offering immense benefits to the microfinance institution; (iii) Supply side constraints such as physical distance to hospitals and a dearth of listed health facilities emerge as binding constraints for program utilization and (iv) Borrowers appear to view health microinsurance as a substitute to public health, evident from a higher rate of program utilization in areas with lower levels of public health infrastructure.

JEL classifications:G21, G22, I10, I12, I13,

Keywords: Health Microinsurance, Microfinance, Pakistan

1 Introduction

Kashf Foundation is a leading microfinance institution in Pakistan, providing affordable financial services to low income households since 1996. Kashf Foundation works with an all-female client base. Therefore, its products and services are women centric, aimed at increasing inclusion, productivity and empowerment of women from a disadvantaged background. Kashf Foundation has a wide geographical spread; reaching out to women in urban and peri-urban areas spanning over Punjab, Sindh and Khyber Pakhtunkhwa.

In Pakistan, lagging health indicators, a low proportion of public health spending, costly private health services, and a large informal sector (which precludes a substantial proportion of the population from accessing employer based insurance schemes) imply that people, particularly women, have limited access to health services.

To cater to this demand, Kashf Foundation, rolled out a large-scale health microinsurance (HMI) program for its borrowers in 2014 which provides coverage to the borrower and all members of the nuclear family. The program was initially pilot tested in 18 branches. By 2015, the program was scaled up to include all of Kashf branches in Punjab and Sindh. Kashfs HMI program is unique on several accounts: (i) *The program is mandatory*: Low take-up rates are an impediment in providing insurance services to the poor in developing countries. As enrollment in this program is mandatory for all women who borrow from Kashf, low take-up rate is not an issue in this

context. (ii) *The program provides coverage to low-income households at both the extensive and intensive margin*. With approximately 1.1 million individuals at present, the HMI program serves as a safety net for a large population at the extensive margin. At the intensive margin, the program provides health services up to 30K to each member of the family in a nuclear household. With a per family member cap instead of a per family cap, this program has tremendous potential for mitigating gender based rationing of resources within low income households. (iii) *The program offers flexibility as well as ease of use*: Kashfs HMI program allows cashless use of health services in empaneled hospitals. In the absence of panel hospitals, the program also offers cash reimbursements. Offering a combination of cashless services (where possible) with cash reimbursements the program provides flexibility and easy utilization of health services by women and their families. (iv) *Insurance cover is provided to women and their nuclear family*: Since Kashf Foundation provides financial services only to women, policyholders of the program are females and the benefits extend to the female's spouse and children.

As of December 2018, Kashf had an active all-women base of 274,274 clients in Punjab (Kashf Administrative Data 2018). Within a short span of 5 years since the roll-out of the HMI program, Kashf has emerged as the largest provider of microinsurance in the country with a market share of 29.4 percent (Microwatch, 2018). This program holds promise for the borrowers; there is a huge potential for decreasing their out-of-pocket health expenditures and reducing their vulnerability to health shocks. In spite of these potential benefits,

users comprise a small proportion of the large population of Kashf borrowers; on average, only 2.85 percent of the borrowers used the program in 2018 (authors own calculations based on administrative data shared by Kashf Foundation).

Kashf Foundation is collaborating with Lahore School of Economics to study the social and economic effects of the HMI program and to explore potential channels through which usage of the program can be increased. An earlier brief, that used administrative data on borrowers and health claims filed between 2014 to 2017 in Punjab, analyzed how usage of the program has evolved across regions and over time, explored various factors that help in understanding differential patterns of program use and examined potential benefits of the program for the microfinance institution (MFI). Our main findings were as follows: (i) women are the most active users of the program with a major focus on seeking health care for maternal and gynecological conditions; (ii) The program can promote client retention, thereby offering immense benefits to the MFI; (iii) Supply side constraints such as physical distance to hospitals and a dearth of listed health facilities emerge as binding constraints for program utilization and (iv) Borrowers appear to view the HMI program as a substitute to public health, evident from a higher rate of program utilization in areas with lower levels of public health infrastructure.

In this brief, we present insights from in-depth focus group discussion (FGD) with 73 borrowers from 5 branches in Lahore. The

rest of the brief is organized as follows: Section 2 lays out a detailed profile of our sample on the basis of their personal characteristics such as age, education and socio-economic status. Section 3 describes the trends in health needs of both program users and non-users. Section 4 explains the perceptions of the respondents about the program's administrative features and its impact on their physical and mental health. Lastly, section 5 identifies the key constraints women face in using the health MI program while providing possible solutions to overcome these binding constraints.

2 Profile of Respondents

In this section, we give a profile of FGD respondents in terms of age, income and education. Figure 2.1a shows the percentage of the respondents in each of the three age groups: young (20 to 29 years old), middle aged (30 to 49 years old) and elderly (50 years or more). We find that more than 60% of the sample is middle aged i.e. between 30 and 49 years of age, while a relatively smaller proportion (around 10%) of the sample is more than 50 years old. Next, we observe the socio-economic status of borrowers on the basis of their income (Figure 2.1b). Almost 70% of the sample has a monthly household income between the range of 20 to 50 thousand PKR. Classifying FGD respondents according to their completed years of education reveals that almost half of the respondents have never gone to school (Figure 2.1c) while around 40% of the respondents had completed at least primary education (i.e. completed grade 5 or more).

Figure 2.1a

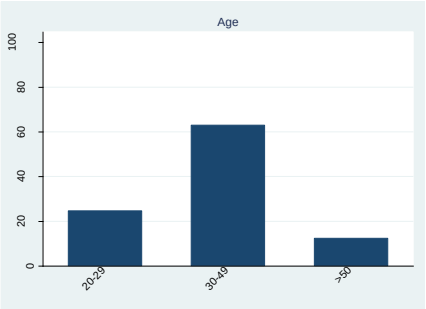


Figure 2.1b

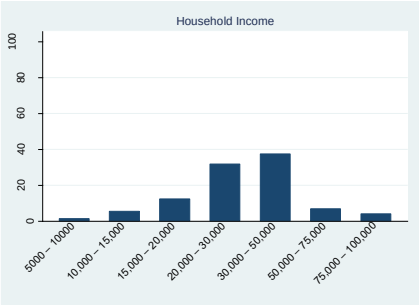
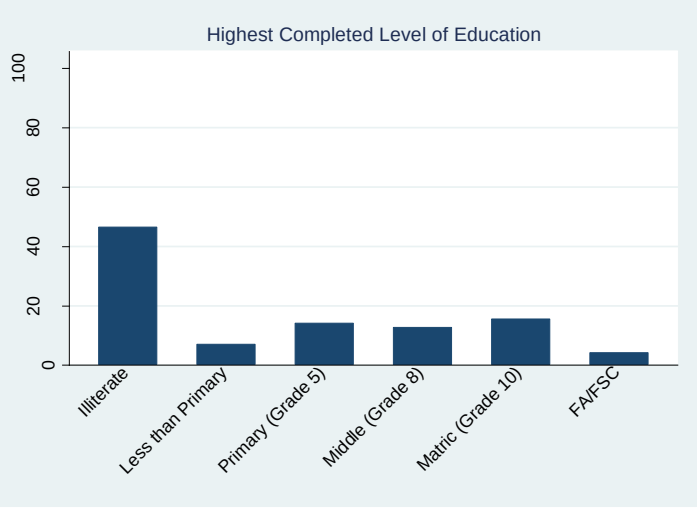


Figure 2.1c



3 Health needs of program users and non-users

In this section, we compare the presence and intensity of health needs amongst program users (i.e. claimants) and non-users (i.e. non-claimants).

The intensity of health needs, as reported by clients, has increased over time and is higher amongst program users as compared to non-program users: In Figure 3.1a, we compare the average number of illness episodes requiring hospitalization which were experienced by program users and non-users between 2010 to 2013; the period preceding roll-out of the program and since the launch of the program in 2014. In Figure 3.1b, we compare average duration of an illness episode (in days) for program users and non-users. Figure 3.1 shows that (i) both users and non-users alike experience an increasing number of illness episodes over time and (ii) program users report 2 while non-users report 1 hospitalization, on average, since the roll-out of the health microinsurance program in 2014.

Despite reporting healthcare needs, a substantial proportion of the clients did not avail health services through the microinsurance program: In spite of facing one illness episode within the household (Figure 3.1a), that lasted for at least 4 days on average (Figure 3.1b), non-claimants did not use the health microinsurance program. This suggests that even though non-users required health-care services but they did not avail them through the microinsurance program. This could indicate

the role of other factors such as lack of information and infrastructure availability (like panel hospitals) as potential constraints to wider utilization of the program. Encouraging current non-users of the program to utilize its services could be an important step towards enhancing well-being of clients by reducing out-of-pocket health expenditures, thereby reducing their vulnerability to adverse health shocks. On the supplier side, this approach could improve cost-effectiveness and promote sustainibiliy of Kashf's microinsurance program. In the next section, we propose potential interventions to overcome these constraints to program use.

Figure 3.1a

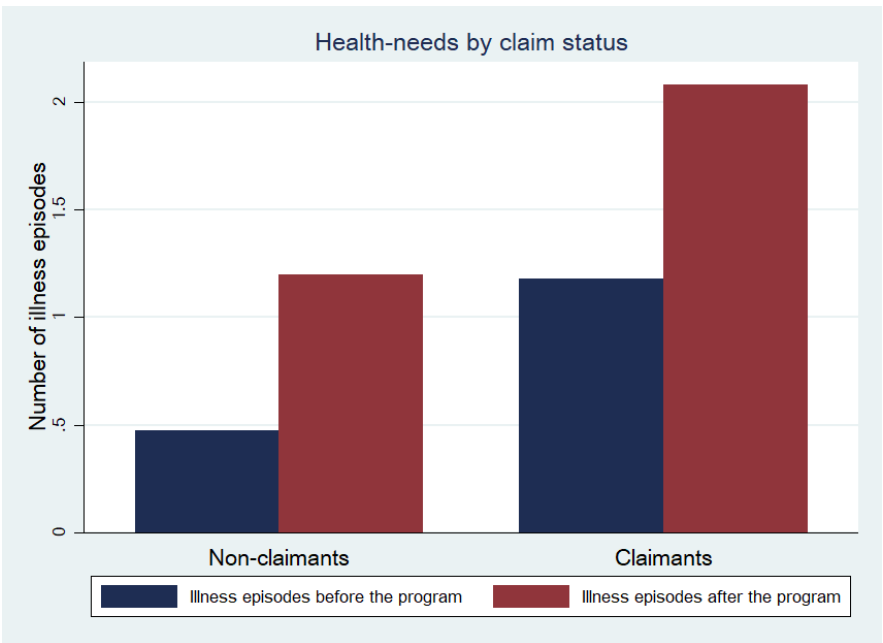
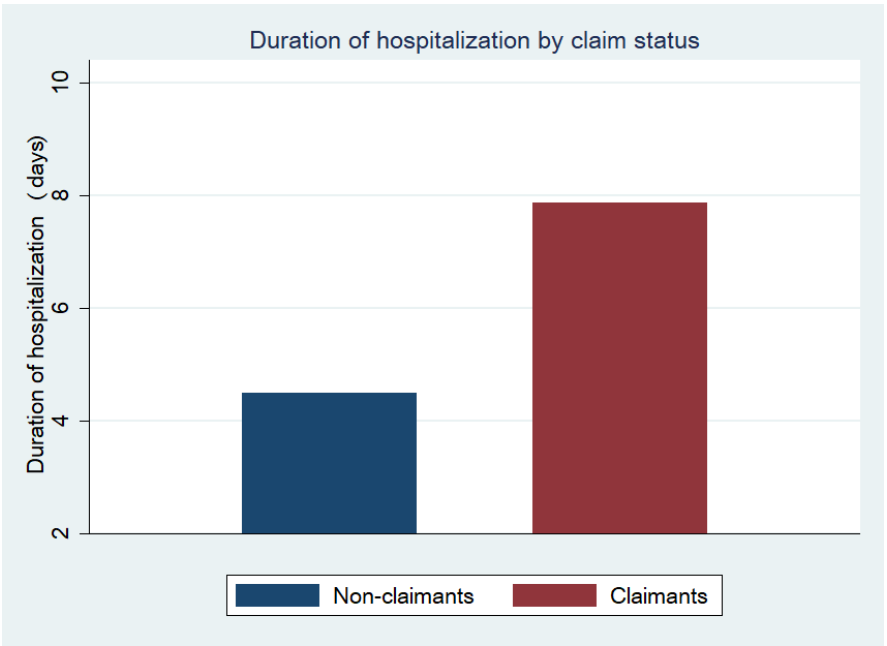


Figure 3.1b


Duration of hospitalization by claim status
Duration of hospitalization (days)
2
4
6
8
10
Non-claimants
Claimants

4 Perceptions about the Program

In this section, we study perceptions of respondents about the HMI program, the role that it plays in their access to healthcare, about its impact on their physical and psychological well-being as well as their status within the household.

4.1 Administrative features of the program

Program users have more favorable perceptions about the usability, reliability and trustworthiness of the program relative to non-users: As a first step we explore perceptions of respondents about administrative features of the HMI program. We asked respondents to let us know the extent to which they agree with each of the following statements about the HMI program: (i) The program is easy to use and understand; (ii) The program is affordable; (iii) The program is reliable and trustworthy; (iv) The program is well marketed. Responses rank from 1 ('Strongly disagree') to 5 ('Strongly agree'). We use shades of green to symbolize if the respondents agree with a statement and shades of red to denote if respondents disagree with a statement. Figure 4.1a summarizes our results on perceptions of clients about various aspects of the HMI program. In general, clients have a favorable perception about the program as evident by the fact that almost 70% of the respondents perceive the program to be "affordable" (i.e. they agree or strongly agree with this statement and rank it as 4 or 5) and around 80% of the respondents consider the program to be "easy to use and understand", "reliable and

trustworthy" as well as "well-marketed to borrowers" (i.e. they agree or strongly agree with each of these statements). Interestingly, respondents who disagree with these statements are largely non-users of the program. For instance, around 20 percent of the respondents disagree with the statement that the program is well-marketed and none of them have ever used the HMI program. This indicates that clients learn-by-doing. So, experiencing the HMI program first-hand seems to boost their perception about the administration, usability, reliability and trustworthiness of the program. These findings also suggest that widespread marketing may be an effective strategy for Kashf to increase usage in areas with a low rate of program utilization.

4.2 Access to healthcare

Users report that the program has improved their access to health services: We assess respondent's perceptions about whether the program caters to their health needs and how it has affected their access to healthcare services as shown in Figure 4.1b. As before, respondents were asked to express their agreement on a scale of 1 (denoting complete disagreement) to 5 (denoting complete agreement) on the following: As a result of the program: (i) "It easier for me to avail medical services for myself as well as my family"; and (ii) "I can prioritize my health and the health of my daughters". We present these results at the top and bottom portion of Figure 4.1b. Around 71 percent of the respondents agree that the program has eased their access to medical services and about 66 percent of the

respondents feel that the program has allowed them to prioritize their own health needs as well as those of their daughters, and these proportions are significantly higher among respondents who have used the program versus those who have never used it.

4.3 Physical Health

Users perceive a positive effect of the program on their physical health and ability to perform day-to-day tasks. To gauge perceptions about the program's impact on physical health of respondents, we asked respondents on a scale of 1 ('Strongly disagree') to 5 ('Strongly agree'), the extent to which they agreed with the following statements: (i) As a result of the program, my health status has improved and (ii) "My ability to perform day to day tasks has improved since enrollment into the HMI program". Our results are summarized in the middle portion of Figure 4.1b. We find that 68 percent report an improved health status. This may either be due to ease of accessing health care services (as reported earlier by the clients) or because of resources being directed away from high out-of-pocket expenditure towards better nutrition of household members. In addition, around 50 percent of the respondents agree that their ability to perform day-to-day tasks has improved since joining the program. Furthermore, favorable perceptions about the program in improving client's ability of performing day-to-day tasks is stronger amongst program users relative to non-users. Taken together, these findings indicate that experiencing the program first hand reinforces

the program's benefits and helps in cultivating good will amongst clients.

Figure 4.1a

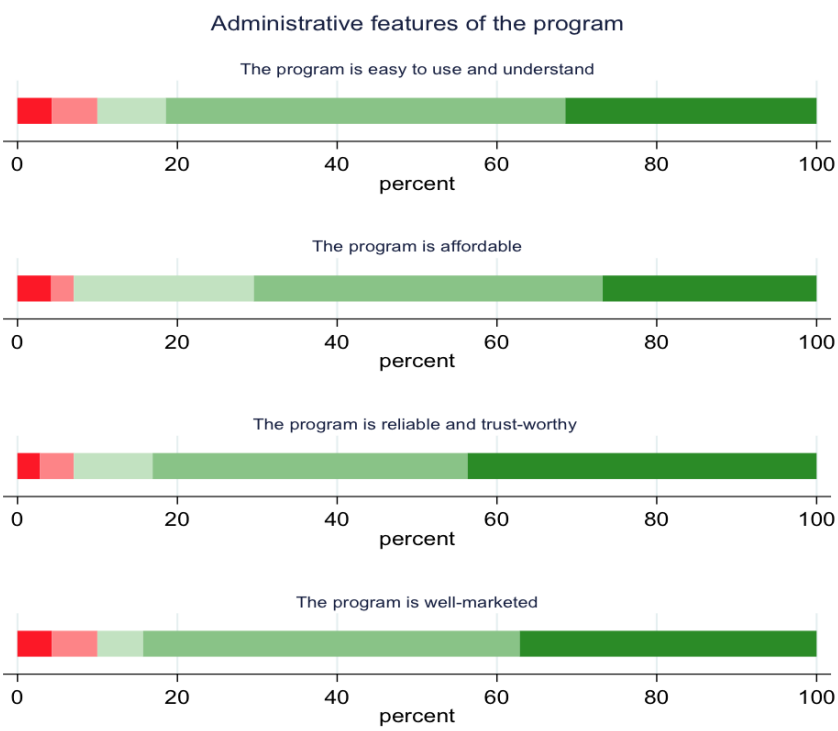
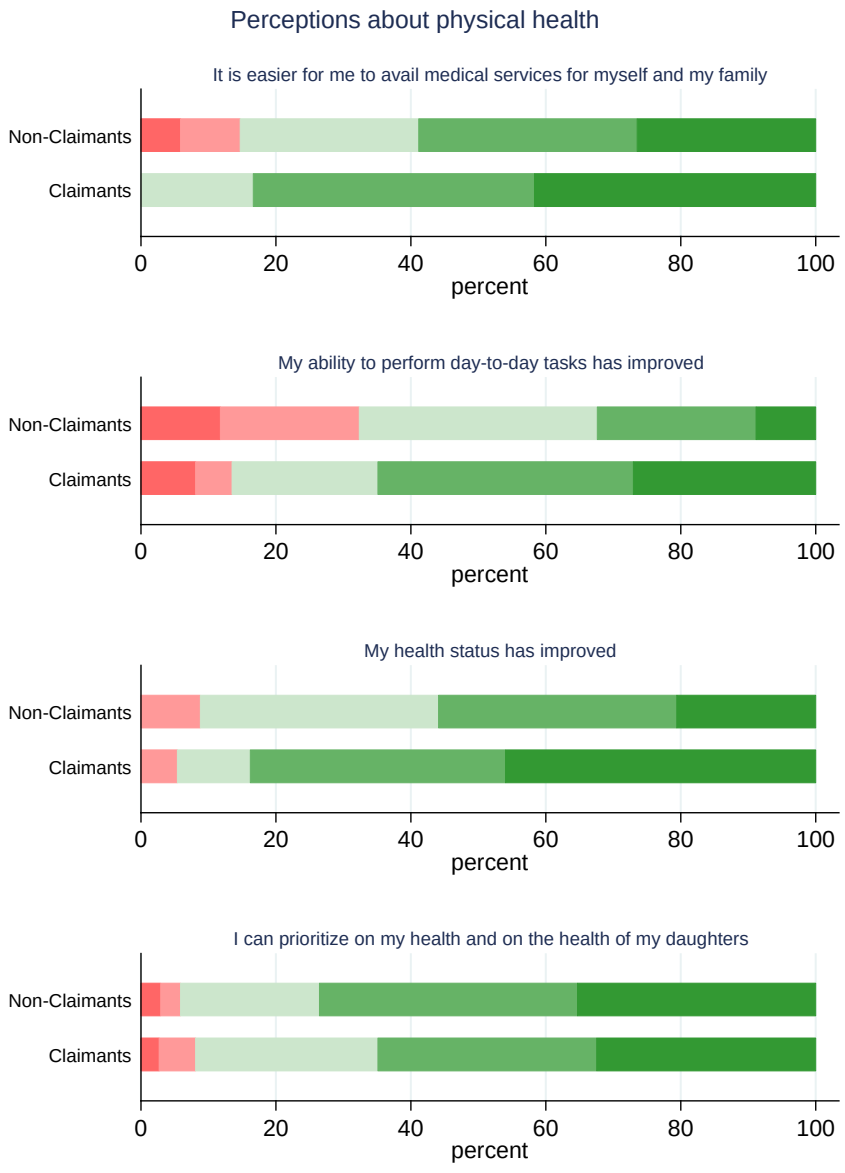


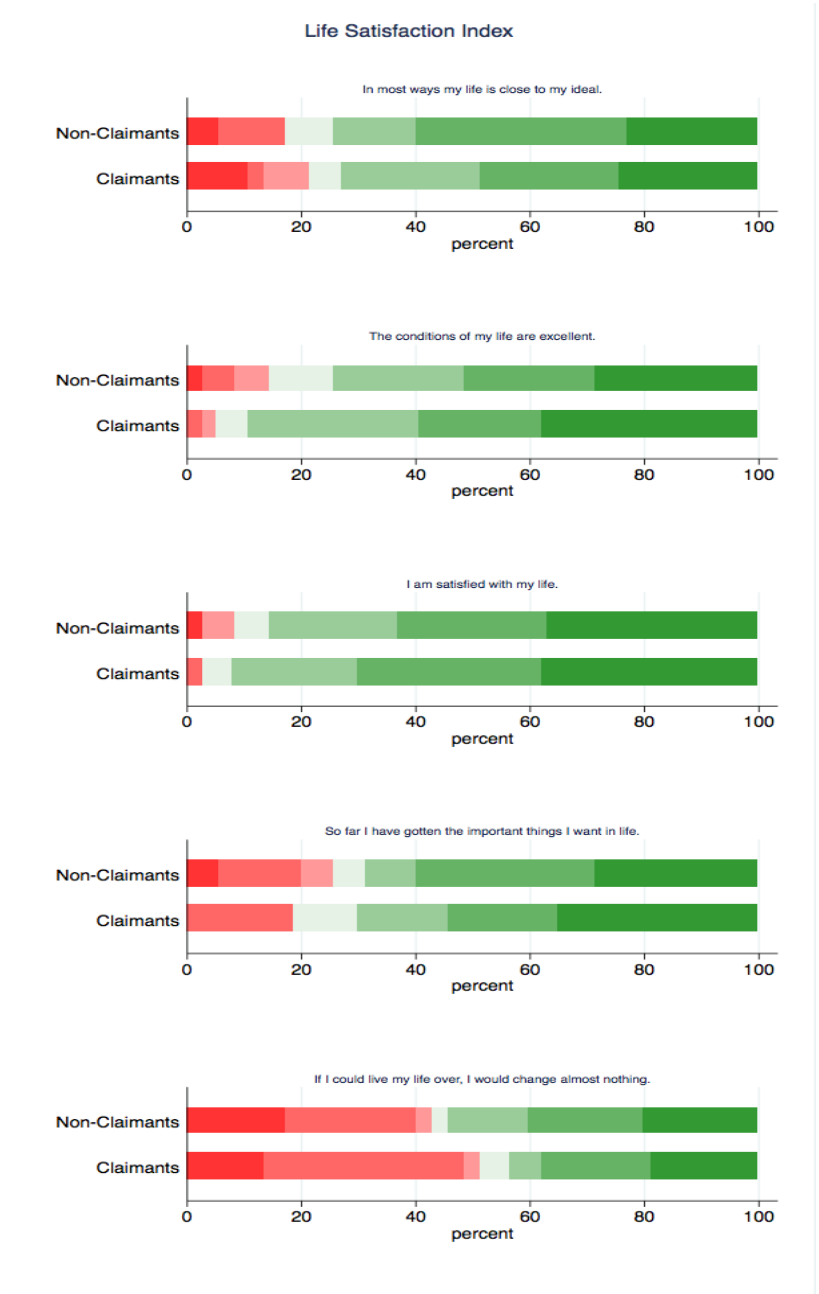
Figure 4.1b


Perceptions about physical health
It is easier for me to avail medical services for myself and my family
Non-Claimants
Claimants
0
20
40
60
80
100
percent
My ability to perform day-to-day tasks has improved
Non-Claimants
Claimants
0
20
40
60
80
100
percent
My health status has improved
Non-Claimants
Claimants
0
20
40
60
80
100
percent
I can prioritize on my health and on the health of my daughters
Non-Claimants
Claimants
0
20
40
60
80
100
percent

4.4 Psychological well-being

Program users tend to be more satisfied with life as compared to non-users. We use the Satisfaction with Life Scale instrument designed by Diener (1985) to measure subjective well-being of individuals. On a scale of 1 (strongly disagree) to 7 (strongly agree), respondents were asked to rank each of the following five statements pertaining to their judgment about their life as per their own standards: (i) "In most ways my life is close to my ideal"; (ii) "The conditions of my life are excellent"; (iii) "I am satisfied with my life"; "So far I have gotten the important things I want in life"; (v) "If I could live my life over, I would change almost nothing". A cumulative score was then calculated ranging from 5 to 35 points, denoting levels of satisfaction ranging from "extremely dissatisfied" to "extremely satisfied" respectively. The results, presented in Figure 4.1c, shows a strong correlation between program users and satisfaction with life. We find program users to be generally more satisfied with their life as compared to non-users. Around 80 percent of the claimants perceived their living conditions and life to be close to their goals. In contrast, we find a greater proportion of non-claimants to be more dissatisfied with life as compared to claimants. Thus program use is positively correlated with a belief of a satisfied and content life.

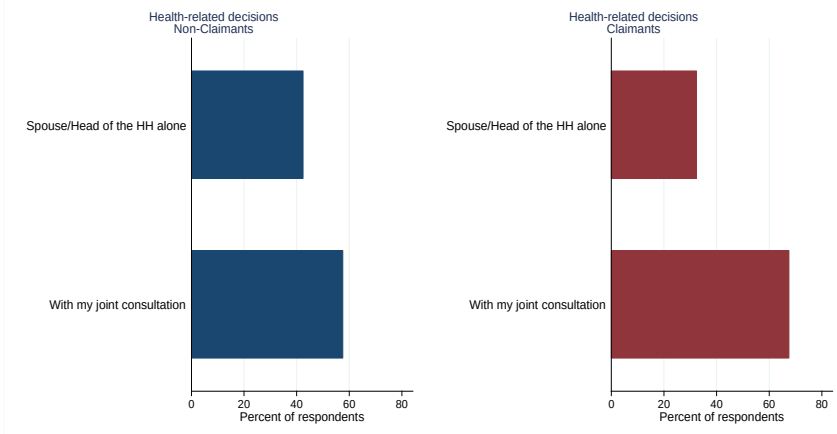
Figure 4.1c


Life Satisfaction Index
In most ways my life is close to my ideal.
Non-Claimants
Claimants
0
20
40
60
80
100
percent
The conditions of my life are excellent.
Non-Claimants
Claimants
0
20
40
60
80
100
percent
I am satisfied with my life.
Non-Claimants
Claimants
0
20
40
60
80
100
percent
So far I have gotten the important things I want in life.
Non-Claimants
Claimants
0
20
40
60
80
100
percent
If I could live my life over, I would change almost nothing.
Non-Claimants
Claimants
0
20
40
60
80
100
percent

4.5 Women's involvement in decision-making

Around 70% users (relative to 58% non-users) report joint consultation in health-related decisions. We asked the respondents about decision-making regarding health-related matters within the household. Figure 4.1d shows that a majority of borrowers reports health related decisions in joint consultation with their husband/ household head. We observe a greater proportion of program users reporting consultative decision-making as compared to non-users. This could indicate that utilization of the program may be correlated with a more inclusive role of women in intra-household decisions. This observation is further reinforced by the fact that more than 40 percent of non-users (as compared to 30% program users) report health decisions to be made solely by the spouse or head of the family without any involvement by the female (Figure 4.1d).

Figure 4.1d



5 Overcoming constraints to program use

In this section, we explore potential constraints that could deter clients from using the program. Based on the clients' responses, we identify two binding constraints namely supply side constraints and information asymmetry.

5.1 Supply-Side Constraints

Around 70% of non-users opted for treatment in a public hospital during the last hospitalization episode. We asked clients about the type of medical facility that either the client or their family members were hospitalized in. In Figure 5.1a, we can clearly see that the users of the program chose private hospital during the last hospitalization episode whereas the non-users of the program opted for a public hospital. To fully understand the preference of program users and non-users for the choice of facility, we ask the respondents about the criteria for selecting a particular type of facility as shown in Figure 5.1b.

Geographical proximity was the most important reason for choosing a hospital during the last hospitalization episode. We asked the clients to state the prime reason for selecting a type of medical facility for the last hospitalization episode faced by their household. Figure 5.1b, depicts that both program users and non-users alike report distance to the facility as the main reason for their selection. From these revealed preferences, we can infer that distance is a binding

constraint for program non-users, who, despite reporting health care needs (Figures 3.1a and b), did not avail the medical services through the HMI program. Figure 5.1c further lends credence to this observation: it shows that the average travel time to a private medical facility (note that only private facilities are covered by the HMI) is higher for non-users as compared to program users.

Figure 5.1a

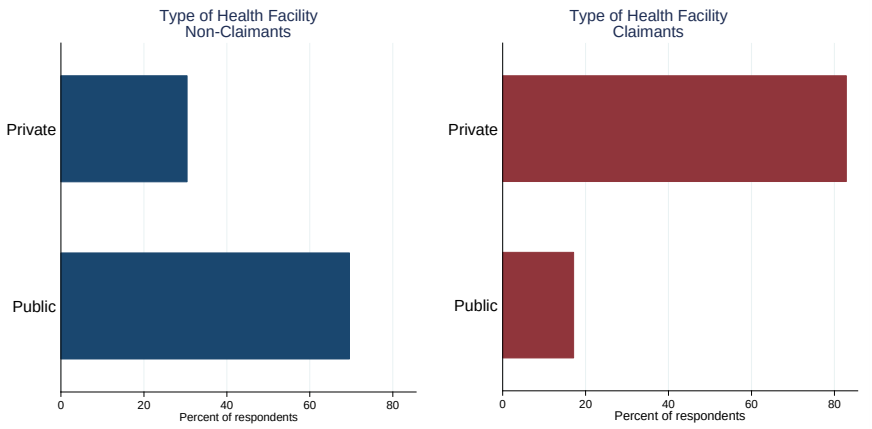


Figure 5.1b

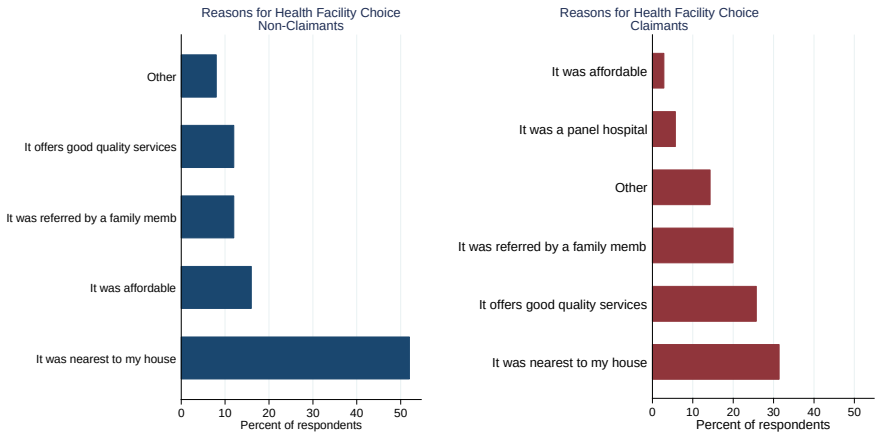
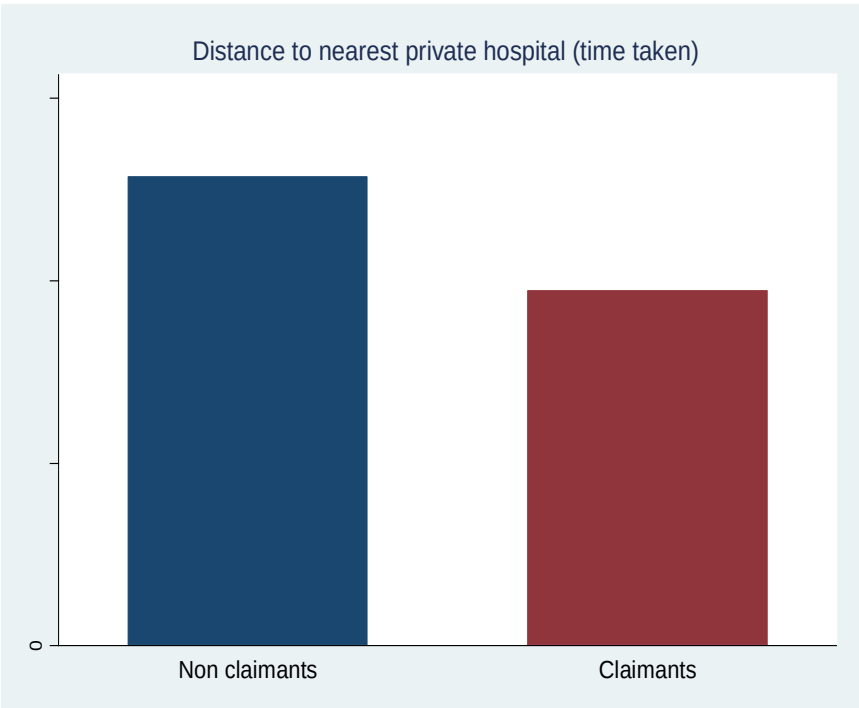


Figure 5.1c



5.2 Information asymmetries

To identify presence of information asymmetries between program user and non-users, we ask the respondents a series of multiple-choice questions to test their knowledge on the following components about the HMI program: (i) Coverage; (ii) Limit for medical treatment; (iii) Type of expenses covered; (iv) Type of diseases covered. Based on their responses, we compute an information index out of 100 which is dependent upon how many correct answers respondents have provided. We illustrate the percentage of respondents who answered correctly on the questions across each of the 5 branches (Figure 5.2a). We rank branches by the rate of program utilization namely "high", "medium" and "low". Three interesting insights emerge:

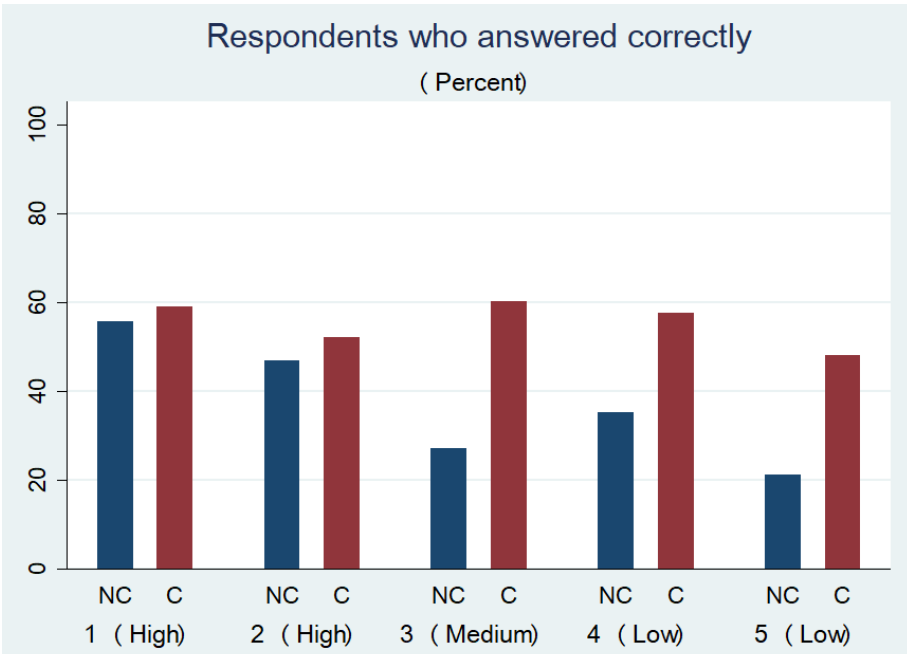
We observe inter-branch heterogeneity in knowledge about the program. For example, in the first branch (with the highest rate of program utilization), around 60 percent of the borrowers answered correctly whereas in the fifth branch (with the lowest rate of program utilization), approximately 30 percent of the borrowers who participated in the focus group discussions answered correctly.

Within each branch, program users seem to have more accurate information about the HMI program relative to non-users. For instance, in branch 5 (which has a "low" rate of program utilization), program users scored 45 percent on average while non-users scored 20 percent on the information index. There appears to be a learn-by-doing

mechanism at play where program use is correlated with better understanding of the features of the HMI program.

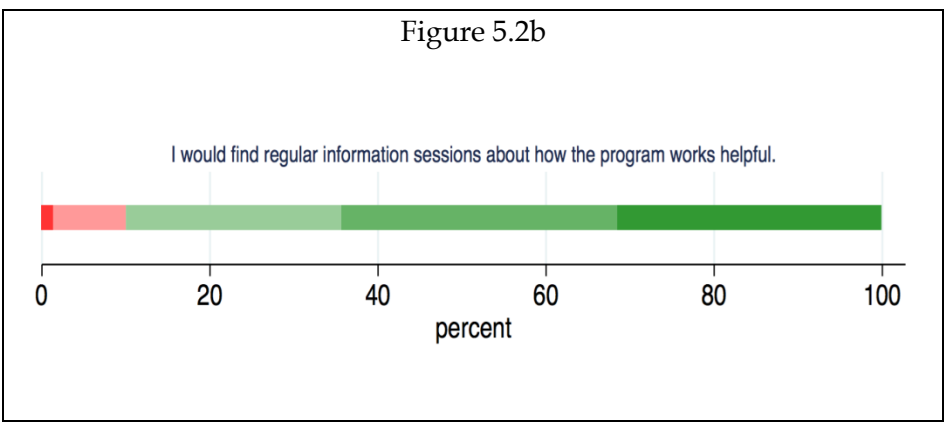
Information asymmetry is more pronounced in branches with low relative to a high rate of program utilization: Figure 5.2a shows that there is a very little variation in the percentage of program-users and non-users who answered correctly in branches where program utilization is "high". In contrast, information gap (as proxied by difference in score of the information index) between the two groups is much more pronounced where program utilization rates ranged from "medium" to "low". These results show that there are information spillovers at the client-level.

Figure 5.2a



The need for an information intervention is corroborated when we asked respondents the extent to which they agree with the following statement: "I would find regular information sessions about how the program works helpful". Responses range from 1 ('Strongly disagree') to 5 ('Strongly agree'). The results are summarized in Figure 5.2b. Around 90 percent of the clients are of a favorable opinion of this statement as represented by shades of green. It is worth noting that program-users too would consider these sessions helpful. In light of these findings, regular information sessions about the features and use of program at the branch-level could mitigate these information gaps.

Figure 5.2b

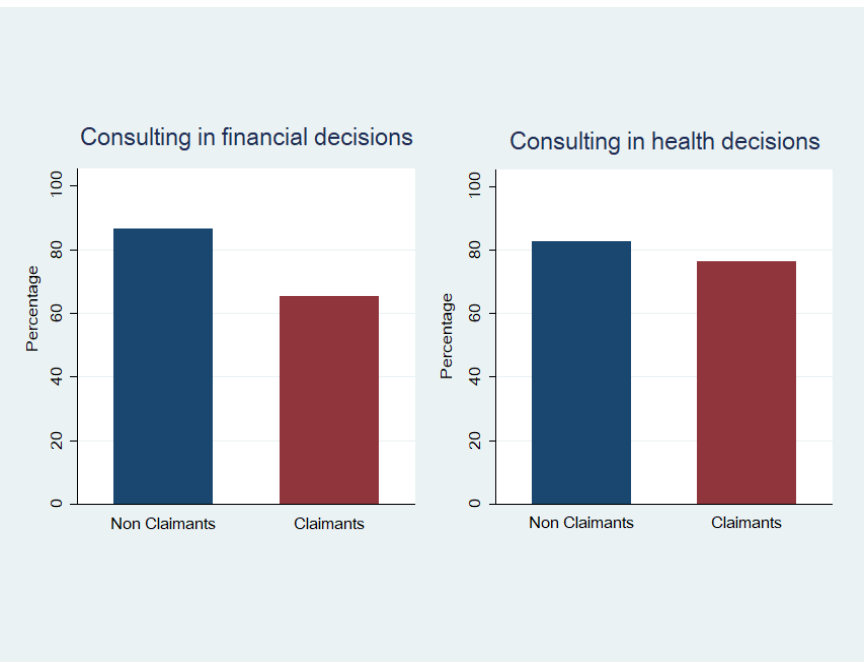


5.3 Leveraging Social Networks

To gauge the importance of social networks for Kashf clients, we ask respondents if they consult their friends and relatives in financial and health-related decisions. Their response is either a "Yes" or "No". We disaggregate this information by program users versus non-users. Figure 5.3a show that 82 percent of the non-users consult

their social networks in making health-related decisions. In contrast, 78 percent of the program users rely on their network in making health-related decisions. A similar pattern is observed when we ask respondents about consultation in financial matters. Around 85 percent of the non-users consult their friends and relatives in making financial decisions as opposed to 65 percent of the program users. We observe a greater reliance on social networks for non-users as compared to program users. Based on this finding, we believe that Kashf could leverage on these social networks to disseminate information about the features and benefits of the program to bolster program use. Such a strategy would enable the MFI to deliver health-services in a cost-effective manner.

Figure 5.3a



6 Conclusion

Kashf Health Microinsurance initiative enables women to access health-care at an affordable price. In this brief, we provide a detailed summary of the insights gained from in-depth focus group discussions with Kashf borrowers about the program. Some interesting findings from this report are as follows:

1. *Women report an improvement in their physical health, psychological well-being and status within the household-* We find an improvement in the reported physical and psychological well-being of women despite experiencing a negative health shock. Further, a greater percentage of program-users report making decisions in joint consultation with their spouse, indicating higher levels of empowerment.

2. *Despite reporting healthcare needs, a substantial proportion of the clients did not avail health services through the microinsurance program.* Women report at least one illness episode in their household after joining health microinsurance initiative, however do not seek health services through the insurance program. This could point towards binding supply-side and information constraints.

3. *Supply-side constraints hamper utilization of health services.* Geographical proximity and availability of a private hospital appear to be important determinants of using the health insurance program. Greater empanelment of hospitals as well as providing transport services to clients could help overcome these supply-side constraints.

4. *Information interventions which leverage the clients' social network could be a cost effective means of promoting utilization in the future.* Women tend to rely heavily on their social networks to make financial and health-related decisions. Dissemination of information through this channel could be an effective strategy to deliver health services for Kashf.

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