

Integrated Healthcare Solutions through Financial Planning with Health Cards

SCBF PUW 2024-08

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Project Summary

Instrument type	Technical Assistance	Project duration	Nov 2024 – Apr 2026
Country of implementation	India	Products	Digital Health Cards, Health Insurance
Financial sector partner(s)	Finhaat	Grantee / TA provider	iKure Techsoft
Targeted segment	Low-income clients	Targeted outreach	39,600 - Health card subscribers (158,400 covered with the health cards)

1. Executive Summary

In India, out-of-pocket expenditure (OOPE) accounts for nearly half of total health spending and pushes ~55 million people into poverty annually, disproportionately affecting rural and low-income households. This project aimed to expand access to affordable primary care and financial protection for underserved populations through a community-led model using iKure Community Health Activists (iCHAs) and the Wireless Health Incident Monitoring System (WHIMS)¹ digital platform. The intervention was implemented beyond Tier I cities across West Bengal, Jharkhand, Odisha, Maharashtra, Karnataka, and Meghalaya, targeting rural and peri-urban low-income households, with a focus on women and Bottom of the Pyramid communities. The solution integrated tiered health cards, subsidised diagnostics, doorstep preventive care, and bundled Hospicash insurance into a low-cost, scalable model. By April 2026, 383 iCHAs were deployed, 55,002 health cards issued covering 181,277 individuals, and 11,954 beneficiaries enrolled in bundled insurance. Beneficiaries accessed diagnostics at 35–65% lower cost, with evidence of reduced out-of-pocket expenditure (OOPE) - general consultations fell by 50–80%, specialist consultations by 60–85%, and diagnostics by 60–65% through partner labs, contributing to an estimated 35–40% reduction in overall household OOPE - and improved preventive health-seeking behaviour. The project also enabled a Community Health Entrepreneur (CHE) pathway for women and introduced chronic care bundles such as Diabetes 360, positioning the model for scale. The digital health card emerged as an effective inclusive finance instrument: by replacing transactional, crisis-driven payments with a low-cost subscription model, it enabled low-income households to plan and pre-budget for healthcare - shifting health spending from an unpredictable shock into a managed household expense. This model offers a compelling proposition for financial inclusion partners, insurers, and impact investors seeking proven, scalable channels to reach underserved populations.

2. Context

India carries one of the largest health financing burdens globally, with out-of-pocket expenditure (OOPE) accounting for nearly 50% of total health spending and pushing over 55 million people into poverty annually. This burden disproportionately affects low-income rural households, where access to qualified healthcare providers is limited and a single hospitalization can result in catastrophic financial shock. In the absence of adequate financial protection, households rely on borrowing, asset sales, or forego treatment altogether, with women and children particularly vulnerable. Baseline survey data from the programme cohort confirmed this pattern: 73% of surveyed beneficiaries reported financial difficulty managing healthcare expenses, and typical

¹ WHIMS (Wireless Health Incident Monitoring System) is a cloud-based SaaS platform operating on Android devices in low-bandwidth rural settings, connecting rural patients with urban doctors, integrating with point-of-care devices such as ECG and glucometers, and enabling centralised monitoring of clinic operations and service utilisation.

coping mechanisms included compromising other household expenses (38%), borrowing (26%), and depleting savings (22%). Only 15% held any form of structured health financing arrangement at the outset.

While the Government of India has made significant progress through schemes such as Ayushman Bharat PM-JAY, which provides secondary and tertiary care coverage for the bottom 40% of the population, a substantial protection gap remains at the primary care level. Outpatient consultations, diagnostics, medicines, and chronic disease management—key cost drivers for low-income households—remain largely uncovered. Preventive healthcare uptake remains low, and early detection of non-communicable diseases such as diabetes, hypertension, and anaemia continues to be inconsistent in rural and peri-urban areas. The commercial health insurance market has historically struggled to serve this segment. Health insurance penetration remains limited among low-income populations, particularly for outpatient and primary care services. Traditional products are often urban-centric, with distribution models that are not viable for small-ticket rural premiums, and low trust further constrains adoption. While Hospicash products are emerging, they are typically offered as standalone solutions through urban channels, with limited integration into primary healthcare delivery systems.

From a policy and regulatory standpoint, India presents an enabling environment. The [National Health Policy](#) and the Ayushman Bharat Health and Wellness Centre framework emphasise community-based care, while the [Ayushman Bharat Digital Mission](#) supports the integration of [digital health infrastructure](#). Additionally, the regulatory ecosystem is increasingly supportive of InsurTech, microinsurance, and innovative financing models. However, last-mile execution remains a critical bottleneck, with limited capital available for community health entrepreneurship and inadequate digital infrastructure among grassroots providers. Given the scale of the problem, the market opportunity for integrated, low-cost health financing solutions is substantial. There is a clear unmet need for products that combine affordability, accessibility, and trust, particularly for primary care and preventive services.

In this context, SCBF funding played a catalytic role. It de-risked early-stage scale-up in a capital-constrained environment, enabled the co-development of a bundled Hospicash product tailored to low-income households, facilitated partnerships with diagnostic and healthcare providers at negotiated price points, and supported the generation of evidence required to attract follow-on public and private investment. The grant was instrumental in demonstrating a scalable model for delivering integrated health financing solutions to underserved populations.

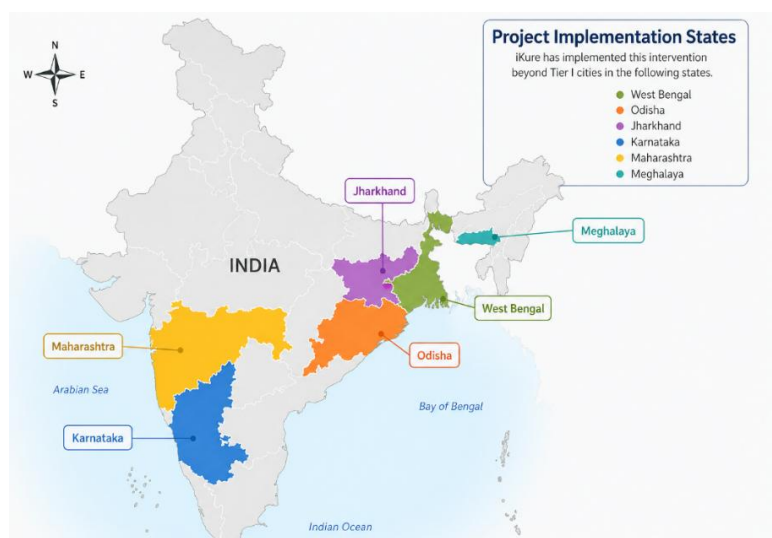
3. Partnership model

Delivery was anchored on a multi-stakeholder ecosystem with clearly defined roles across community cadre, diagnostics, insurance, and technology.

- **iKure Techsoft** led implementation – designing and managing the iCHA cadre, operating WHIMS, leading product design for the tiered health card and bundled Hospicash, and holding accountability for last-mile delivery, claims, and impact measurement.

- **Diagnostic and clinical partners** –

[Metropolis Healthcare Limited](#) in Maharashtra, alongside [MCS Multispeciality Hospital](#), [Sanjeevani Nursing](#)



[Home and Eye Care](#), and [Nayan Disha Eye Foundation](#) – enabled 35–65% price reductions on diagnostics, with sample collection through iKure clinics and digital reporting routed via iCHAs.

- **Insurance and financial partner Finhaat** supported the rollout of bundled Hospicash, with claims cross-validated through backend reconciliation to ensure transparent, timely payouts.

4. Intervention approach

The intervention delivers affordable primary care and financial protection through a simple, integrated product: a tiered digital health card, optionally bundled with Hospicash. The health card is designed to match household affordability and provides access to discounted general and specialist consultations (₹100–₹600), teleconsultations (₹100–₹300), 10–20% savings on medicines, and up to 60–65% discounts on diagnostics through partner laboratories. Doorstep services, including vitals monitoring (BMI, SpO₂, pulse, blood pressure) and counselling, are provided free of cost. The bundled Hospicash component offers additional financial protection against hospitalization shocks, reducing catastrophic expenditure risks.

The product is distributed through a community-led model, leveraging trained iKure Community Health Activists (iCHAs), predominantly women, who conduct doorstep outreach, enrolment, and follow-up care in rural and peri-urban areas beyond Tier I cities. The iCHA-to-Community Health Entrepreneur (CHE) pathway (L0–L3) provides a structured progression framework, enabling capacity building, performance-based incentives, and long-term livelihood generation. Selected from within their own communities, iCHAs progress through four structured levels: L0 (Grassroots) – community mobilisation, surveys, and household engagement; L1 (Digitally Enabled) – digital registration, basic vitals collection, counselling, and medicine coordination through WHIMS; L2 (Senior) – doorstep diagnostics, teleconsultation coordination, stakeholder engagement, and health card sales; and L3 (Skilled) – advanced screening, quality assurance, mentoring of junior iCHAs, and coordination of care pathways before transitioning into Community Health Entrepreneurs (CHEs).

The intervention is supported by the WHIMS digital platform, which enables real-time beneficiary registration, service utilisation tracking, and monitoring of iCHA activities. Financial transactions and Hospicash claims are digitally recorded and cross-validated, with monthly MIS reconciliation ensuring data accuracy and transparency across geographies. SCBF funding supported key high-impact areas, including WHIMS platform upgrades, onboarding and training of iCHAs, development of bundled Hospicash products, strengthening diagnostic and provider partnerships, and deployment of gender-inclusive field tools.

Gender inclusion is embedded in the model through a predominantly women-led workforce, targeted outreach to women and high-risk pregnancies, gender-disaggregated tracking of enrolment and utilisation, and the CHE pathway that enables sustained economic participation of women in underserved communities. Financial literacy is integrated into all beneficiary interactions, with iCHAs delivering structured counselling on health financing, risk pooling, product usage, and claims processes, thereby improving informed decision-making and encouraging preventive health-seeking behaviour.

5. Results, outcomes and impact

Key KPIs	Achieved results (by end of the project – April 2026)
Total iCHAs	383
Total health cards issued	55,002
Total people covered under health card (benefitted including family members)	181,277
- Number of women	88,866

- Number of people from rural area	136,532
- Number of people under the age of 35 years	49,110
- No of Below Poverty Line (BPL) members covered under health cards	37,521
Total health cards (people covered) + insurance	11,954
- No of women covered under health cards + insurance	8,341
- No of BPL members covered under health cards + insurance	2,145
- % rural population covered under health cards + insurance	9,235
Total number of people reached through financial literacy awareness	181,277
- Number of women trained in financial literacy	383
% reduction in out-of-pocket health expenditure of the cardholders	35-40%
Number of total clients covered under Health Insurance	11,954
Number of clients that got claims pay-out	523

By the end of the project, a total of 181,277 clients were served through iKure's health financing intervention. Operating primarily beyond Tier I cities, iKure has focused on reaching underserved rural and peri-urban populations with 136,532 clients from rural areas, while the remaining were from peri-urban or urban locations. Of the total beneficiaries, 88,866 were women, which builds on its ongoing maternal care programs where health cards were introduced to improve access and affordability. Additionally, 49,110 beneficiaries were under the age of 35, indicating substantial outreach among youth. Resubscription trends indicate steady renewal behaviour across plans, with 566 re-subscribers in the Starter Plan, 1,977 in the Silver Plan, and 1,177 in the Platinum Plan, reflecting continued engagement and perceived value among beneficiaries. The Diabetes 360 package (a comprehensive diabetes screening and management programme offered at ₹599, covering blood sugar testing, HbA1c, lipid profile, ECG, diabetic specialist consultation, diet and lifestyle counselling, foot check-ups, eye screening, and access to medicines, with additional diagnostic support and ambulance or hospital admission assistance available when required) has been rolled out across West Bengal, Jharkhand, Maharashtra, and Karnataka, with a total of 5,968 beneficiaries registered to date.

Features / Benefits	₹99 Starter	₹299 Silver	₹499 Gold	₹599 Platinum
Beneficiaries Covered	Individual	Up to 4 members	Up to 4 members	Individual
Discounted Diagnostics	✓	✓	✓	✓
NCD Screening & Management	✓	✓	✓	✓
Doorstep Vital Monitoring	✓	✓	✓	✓
Teleconsultation Access	✓	✓	✓	✓
Specialist Consultation Access	1 Consultation / Eye Screening	Limited Access (Upto 2 consultations per month)	Unlimited / Multiple Access	Unlimited / Multiple Access
Medicines & Spectacles Discounts	✓	✓	✓	✓
Eye Screening & Vision Tests	—	✓	✓	✓
Tertiary Healthcare Support	—	✓	✓	✓
Ambulance Support	—	—	Subsidized	Subsidized
Hospicash Coverage	—	—	—	₹1,000/day (30 days) or ₹2,000/day (15 days) of upto ₹30,000

The intervention achieved an estimated 35–40% reduction in out-of-pocket expenditure (OOPE) at the household level – with 89% of beneficiaries reporting annual healthcare costs within ₹10,000 by endline, compared to only 60% at baseline. This was underpinned by over 50% cost savings across key healthcare services, and crucially, a measurable shift in behaviour: beneficiaries moved away from delayed, crisis-driven care toward planned, preventative health-seeking. Early screening uptake for diabetes, hypertension, and anaemia increased, and reliance on borrowing or asset sales during health shocks declined significantly. The endline survey (n=16,031) quantifies these shifts: 91% of beneficiaries reported some level of OOPE reduction (18% significantly, 73% somewhat), and 86% reported reduced financial stress on health-related costs. The share of households reporting borrowing or asset sales to meet a health cost fell from 26% at baseline to 7% at endline. Doctor visit patterns shifted decisively away from crisis-driven care: 83% of surveyed beneficiaries now visit a doctor at least once a month, while emergency-only visits stand at just 3%. Equally, 71% of households reported planning their annual health expenditure in advance – a concrete marker of the shift from unpredictable health spending to a managed household budget. The share of beneficiaries holding any structured health financing arrangement moved from 15% at baseline to 97% at endline.

The bundled Hospicash component further strengthened financial protection, with 11,954 beneficiaries enrolled and 523 claims settled (approximately 5% of those enrolled, primarily for cataract surgeries, emergency hospitalisations, and maternal deliveries), reducing the financial shock associated with hospitalization. The intervention also produced a measurable shift in the hospitalisation profile. At baseline, crisis-driven hospitalisations dominated – diabetes complications (46%) and GI complications (22%) were the primary reasons. By endline, the mix had shifted decisively toward planned and elective care: cataract surgery (51%) and pregnancy-related admissions (47%) accounted for almost all hospitalisations, with crisis-driven events falling to just 2%. This shift is consistent with the programme’s intent to enable financed, planned care rather than reactive emergency spending. Routine NCD screening also drove improved detection: the share of beneficiaries identified with diabetes rose from ~30% at baseline to 53% at endline, reflecting stronger uptake of preventive diagnostics rather than an increase in incidence.

Beneficiary feedback indicates behaviour change: households that previously avoided care due to cost now access diagnostics, consultations, and medicines regularly through the health card. Resubscription across plan tiers – 566 in Starter, 1,977 in Silver, and 1,177 in Platinum – representing 3,720 total resubscriptions and approximately 63% of those eligible for renewal (noting that a large proportion of beneficiaries are still within their first annual subscription cycle and not yet due for renewal) – confirms sustained engagement and perceived value, while the strong uptake of the Silver Plan (which does not include insurance) signals that communities are actively investing in day-to-day health financing, not just crisis coverage.

A total of 383 iKure Community Health Activists (iCHAs) were on-boarded and trained to support the delivery of health financing services to low-income communities. They are equipped with health financing product awareness (health cards and bundled Hospicash), financial literacy counselling, community mobilisation and enrolment, basic health screening and referral pathways. Through this capacity building, iCHAs acted as key last-mile enablers, supporting low-income clients in understanding, accessing, and utilising affordable healthcare and financial protection services. Financial literacy was delivered to beneficiaries through iCHA-led enrolment, counselling, and follow-up interactions, making it an embedded component of service delivery rather than a standalone training activity. As a result, all enrolled beneficiaries were exposed to key financial literacy concepts, including risk pooling, preventive care, and insurance usage. Of the 383 active iCHAs, 27 progressed to the Community Health Entrepreneur (CHE) role during the project cycle, taking on community-

level advocacy, stakeholder engagement with local unions and panchayats, and peer mentoring responsibilities - an early but meaningful realisation of the iCHA-to-CHE livelihood pathway.

The project met all major outreach and inclusion targets, with particularly strong overachievement in health card uptake, women and rural inclusion and overall beneficiary coverage. This indicates higher-than-expected demand, effective community-based delivery, and strong acceptance of the bundled health financing model. The project exceeded initial targets across key indicators, including beneficiary outreach, health card issuance, and women and rural inclusion. The scale achieved reaching over 181,277 beneficiaries against planned targets reflects strong demand and effective last-mile delivery through the iCHA network.

At the outset, the project committed to scaling access to affordable primary care and financial protection through health cards and bundled insurance. By endline, these targets were exceeded, with 55,002 health cards issued, 181,277 beneficiaries reached, and 11,954 beneficiaries enrolled in Hospicash, reflecting strong demand, effective community-based delivery, and high acceptance of the model.

Client Feedback



← **Picture 1:** Through iKure's health financing initiative, the beneficiary (Miss L. Ghughu) received continuous maternal care with regular doorstep ANC screenings and follow-ups, ensuring a safe pregnancy. She accessed subsidised diagnostics at Krishna Diagnostics and delivered safely at MCS Superspeciality Hospital. With support from the Health Card and HospiCash (₹1000/day during hospitalization), her financial burden was significantly reduced, enabling a healthy recovery for both mother and baby.

→ **Picture 2:** A beneficiary's wife (Mrs. Jha) recently underwent cataract surgery, with iKure ensuring a seamless care journey. Through the Health Card



and Hospicash service, hospitalization costs were significantly reduced, and medicines and diagnostics were accessed at discounted rates at Nayan Disha Hospital. Continuous support from iCHA health workers - including admission assistance, regular vitals monitoring, and doorstep delivery of medicines - made the entire treatment process affordable and stress-free, reducing the family's financial burden despite limited external support.

Picture 2: Mrs. Jha during her first visit post-surgery

The funding was used to strengthen last-mile delivery, expand the iCHA workforce, enhance the WHIMS digital platform, and support the rollout of bundled health financing products.

The project enabled iKure to attract follow-on interest from both public and private stakeholders, including partnerships with diagnostic providers, and other healthcare networks. The project demonstrated that integrated, community-led health financing models are viable and scalable in low-income rural markets, where traditional insurance models have struggled. By successfully combining primary care, diagnostics, and Hospicash into a single, affordable offering, the intervention showcased a replicable model for improving financial protection and healthcare access. The strong uptake, high service utilisation, and measurable

reduction in OOPE provided proof of concept for insurers, healthcare providers, and policymakers. This has begun to influence market behaviour by encouraging greater interest in bundled microinsurance products, partnerships with community-based distribution channels, and digitally enabled care-financing models for underserved populations.

The project delivered strong and measurable outcomes, reaching 181,277 beneficiaries, including 88,866 women and 136,532 rural individuals, demonstrating deep inclusion. It successfully scaled a community-led model with 383 trained iCHAs, enabling effective last-mile delivery and trust. A key achievement was the high uptake of bundled health financing, with 55,002 health cards issued and 11,954 beneficiaries enrolled in Hospicash, exceeding initial projections indicating strong demand and effective community-based delivery. The intervention led to a 35–40% reduction in OOPE and over 50% cost savings, meaningfully improving financial resilience for low-income households. Equally important is the documented behaviour change: communities shifted from crisis-driven care to planned, preventive health-seeking – a transformation in how low-income families relate to health spending. Overall, the project validated a replicable model that integrates primary care, diagnostics, and financial protection; creates livelihood opportunities for grassroots women through the iCHA-to-CHE pathway; and establishes the digital health card as a proven vehicle for financial inclusion at the last mile.

6. Way ahead: Future scaling and sustainability plans

Following the SCBF-supported phase, the intervention is consolidating in core geographies and expanding into new markets. In India, operations are extending from West Bengal, Odisha, Jharkhand, Karnataka, Maharashtra, and Meghalaya into Bihar and Ladakh, each chosen for density of underserved populations and alignment with state health priorities. Select Southeast Asian markets, where community-based primary care gaps mirror India's, are under evaluation for pilot within the next 12–18 months.

Product depth will scale in parallel. Building on the Diabetes 360 proof-point, integrated care bundles are being readied for maternal health, hypertension, eye care, respiratory care, and sickle cell anaemia each structured around screening, treatment, monitoring, and referral. Insurance cover will expand beyond Hospicash to broader protection products designed for low-ticket, high-volume distribution through the iCHA cadre.

Sustainability is anchored on three revenue streams: health card subscriptions, margin on diagnostics and teleconsultations, and commissions from bundled insurance. The Community Health Entrepreneurs (CHE) model drives unit economics by converting community cadres into performance-linked entrepreneurs, reducing fixed distribution costs as the network scales. Longitudinal beneficiary data captured in WHIMS strengthens product design, underwriting partnerships, and outcome-based financing opportunities with public and private payers. At endline, health card subscriptions represent approximately 45–50% of earned revenue, diagnostics and teleconsultation margins 20–25%, and insurance distribution commissions 10–15%, with the remaining 20–25% from time-bound programmatic and outcome-linked instruments. The trajectory for the first three streams is upward as the subscriber base, service utilisation and Hospicash renewals grow; the programmatic component is expected to decline as recurring earned revenue scales.

Building this longitudinal evidence base is a central priority for the next phase. Leveraging WHIMS and the iCHA community health network, iKure will strengthen long-term patient tracking and outcome measurement, with particular emphasis on non-communicable disease (NCD) outcomes and, where direct clinical outcomes are not yet measurable, robust proxy health indicators. Tracking defined cohorts over successive subscription cycles is intended to evidence the health impact of sustained engagement, sharpen underwriting partnerships, and unlock outcome-based financing with public and private payers.

Strengthening renewals across both health cards and insurance products is an explicit focus for the next cycle. A large share of beneficiaries remain within their first annual subscription cycle and are not yet due for renewal; as these cohorts mature, iKure will deploy a structured retention strategy combining systematic renewal tracking, family-based plans, and targeted, timely engagement. Early-intervention prompts and automatic and family renewal options are being designed into the beneficiary journey to lift retention across all plan tiers rather than addressing lapses after the fact. On the insurance side, reinsurance and Hospicash renewals will be monitored closely as the first full insurance cohorts complete their policy year, providing the early read on persistency needed to inform pricing, product design, and partner arrangements.

7. Lessons learnt and recommendations

The following outcomes worked well for iKure:

- Bundled financing model (Health Card and Hospicash) significantly improved uptake by combining immediate, visible benefits (discounted primary care) with financial protection for hospitalization, reducing hesitation toward insurance products.
- Community-led distribution through iCHAs proved highly effective in building trust and improving adoption of financial products in markets where formal insurance penetration is low.
- Bundling with preventive and primary care services shifted the value proposition from reactive insurance to proactive health financing, encouraging early care-seeking behaviour.
- Digitally enabled tracking via WHIMS improved transparency in utilisation, claims, and beneficiary records, strengthening trust and enabling better intervention management.

The following did not work well:

- Standalone understanding of insurance products remained low, and despite bundling, initial uptake of Hospicash required significant trust-building and repeated engagement, slowing early conversion rates.
- Variability in diagnostic partner pricing and quality affected the consistency of the value proposition, weakening beneficiary confidence in the overall financing package in some geographies.
- Insurance utilisation remained relatively low compared to enrolment, limiting immediate perceived value for some beneficiaries and requiring stronger communication on long-term benefits.

Key assumptions confirmed:

- Willingness to pay exists among low-income rural households when healthcare financing is simple, affordable, and delivers immediate, visible value.
- Trust-based, community-led distribution is far more effective than purely digital or agent-led models in low-income settings.
- Preventive and primary care integration drives earlier utilisation and reduces reliance on high-cost emergency care.

Key constraints and how they were addressed:

- Low initial trust and awareness of insurance products: Addressed through iCHA-led counselling, repeated engagement, and leveraging existing trust in health services.
- Drop-offs across the referral and care continuum: Reduced through active iCHA follow-ups, patient navigation support, and linking Hospicash to hospitalisation events.
- Operational challenges in scaling across geographies: Managed through phased expansion, localised partnerships, and adaptive field strategies.
- Cadre supervisory capacity at scale: The supervisory model that worked in early districts required structural adjustment as the iCHA cadre expanded across multiple states. Cluster coordinator capacity and field audit

cadence proved to be binding constraints. Building supervisory infrastructure ahead of, rather than in parallel with, cadre expansion is a key operational learning carried into the next cycle.

What we would have done differently:

- Established stronger partner governance earlier, including SLAs, pricing controls, and quality benchmarks for diagnostics and hospitals.
- Strengthened beneficiary education on insurance value upfront to improve utilisation and perceived benefits.
- Front-loaded claims-process communication at enrolment: beneficiaries who received a clear walk-through of the Hospicash claims process before their first policy month showed stronger confidence in the instrument. This should be a standard component of the enrolment journey rather than addressed only at the point of a hospitalisation event.

Top 5 recommendations for future initiatives:

- Adopt bundled health financing models that combine primary care, diagnostics, and insurance to improve uptake and retention.
- Invest in community-based health workers as distribution channels, particularly women-led cadres, to build trust and drive adoption.
- Integrate financing with service delivery ecosystems, ensuring that financial products directly translate into care utilisation.
- Establish strong provider networks early, with standardised pricing, quality assurance, and referral protocols.
- Embed robust data and impact measurement systems from inception to enable real-time learning, course correction, and evidence generation for scale.
- Build cadre supervisory infrastructure ahead of cadre expansion: sequencing supervisor capacity and field audit systems before scaling the iCHA workforce avoids the quality and consistency gaps observed when the two are done in parallel.
- Develop claims-linked awareness assets integrated into routine iCHA household engagement: short, visual, locally translated materials that walk beneficiaries through the claims process at enrolment and at each service touchpoint strengthen Hospicash utilisation and perceived product value throughout the policy year.