



Addressing Vulnerability through Microfinance

Health Insurance: Opportunities and Challenges

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In rural India, poor households face considerable risk in both their professional occupation and their personal lives. Very few of them have any access to formal insurance against any of these risks. One particularly important source of risk comes from health shocks. A single bad health shock can cost thousands of rupees, undermining savings or forcing households to take loans. Governments and civil society organizations have thus felt the need to provide health insurance to the poor. The provision of insurance to the poor runs into considerable implementation challenges, however. Reaching and insuring a large number of individuals is necessary to achieve operational sustainability, and to avoid the classical problems facing health insurance, such as adverse selection (i.e. the risk that people who know to be sick are more likely to join the insurance pool).¹

Microfinance institutions (MFI) have the potential to solve this problem. They reach large number of clients, from whom they collect repayment on a weekly basis. They have thus the ability to reach a very large client base in a very cost effective way, which makes it possible to keep the premiums to a minimum. Moreover, since the main reason the clients join the organization is to get a loan, making insurance mandatory for the client of the organization can mitigate the adverse selection. Several MFI have thus started to introduce catastrophic health insurance as part of their service to their clients. However, many questions remain unanswered: Does health insurance discourage clients from staying clients of the MFI? Does it encourage only the sicker clients to stay enrolled, which would threaten the main line of business of the MFI? What is the benefit to the clients of being enrolled (health benefits, economic benefits, etc.)? Does the availability of health insurance help client overcome health crises, maintain better businesses, and ultimately repay their microfinance loans?

To answer all these questions, the Center for Micro Finance (Chennai, India), the Abdul Latif Jameel Poverty Action Lab (J-PAL South Asia and J-PAL at MIT) and SKS microfinance set up a randomized experiment to evaluate the impact of offering health insurance to micro-lending clients. While SKS is already working in several hundreds of villages and has insured close to 50,000 lives, two hundred and one villages were selected for the pilot study and 101 of these villages were randomized into the treatment group where clients purchase health insurance at the time they renew their loan. The 100 remaining villages form the comparison groups. The health insurance product will be rolled out in those villages after two years. The loans and insurance products are administered by SKS in the state of

¹ This analysis is based on the work of many people. We thank Alison Comfort (Harvard School of Public Health) who analysed the data, the CMF team which implemented the project, Ruchi Singh, Vinod Kumar, Raj Pathak (SKS) who supervised the administration of the SKS health insurance product, Vikram Akula (SKS CEO) for his support and inspiration, and countless loan officers and SKS clients.

1 This study was conducted as part of a CMF project. The following CMF RAs managed this project: Kalyan Neelamraju, Theresa Chen, Shwetambara, and Anvesha Khandelwal. For more information, see http://ifmr.ac.in/cmfm/?page_id=447

Karnataka, and provided by ICICI Lombard. The data cover 7,000 households and about 28,000 adults.

This note presents preliminary findings from the analysis of part of the baseline data, and the experience of SKS since the health insurance has been introduced. The analysis reveals that the insurance has not led to client dropping out in the villages where it was introduced, and has not adversely affected the composition of SKS clients. The health insurance product is well understood, and well used by clients. The data therefore suggests that microfinance institutions are indeed effective channels for the delivery of health insurance. Future research will assess the benefits to the clients.

Note that all these results are highly preliminary and subject to change when more data becomes available.

The need for insurance: evidence from the baseline survey

The baseline data reveals a considerable unmet demand for insurance. Less than a percent of the household have accident or health insurance. Yet, they face frequent health shocks: in the last year, 93% of the households have experienced a serious health event, requiring an expense of at least Rs 300, an hospitalization, or keeping them away from work for more than a week at a time). 40% of the household experienced at least two of these shocks. 6% of the households had at least one member hospitalized.

The average health event costs Rs 1,900, while the average monthly expenditure per capita is Rs 708. The distribution of these costs is very skewed: 5% of the households are responsible for 87% of the expenditures on these major health event. When they face an adverse health event, 43% of the households resort to a loan to face the expenses (the vast majority of others use household savings). 32% of these loans are obtained from a money lender.

Thus, this data suggests that SKS households, despite the fact that they are already members of a microcredit organization, are facing considerable financial risk due to health events. Bundling catastrophic health insurance with the main microfinance product thus seems a promising avenue.

The insurance product

The insurance policy (administered by ICIC Lombard) covers catastrophic costs which include costs related to maternity, hospitalizations, and accidents. The client must insure herself, and can include her husband as well as up to two children. The premium, including administration fees, varies from Rs. 350 to Rs. 525 depending on the number of family members covered. The policy includes annual premiums, but does not include co-payments or deductibles.

The insurance products are rolled out progressively in SKS work area, starting with northern Karnataka. When the product is introduced in a center, a specialized team first meet clients, explain the product to them, and shows a video produced by SKS.

In order to minimize adverse selection while only minimally affecting SKS core business, the purchase of health insurance was made mandatory for SKS clients in centers where the health insurance was introduced at the time of the renewal of the loan. When clients become eligible for a midterm loan or

need to renew their main group loan, they must purchase health insurance as well if they want to become member.

Did health insurance affect SKS client pool?

While one of the goals of the insurance product is to ensure financial protection for those most at risk of having serious health shocks, the sustainability of these schemes depends upon the ability of the scheme to attract a large cross section of individual, to mutualize the risk. It is thus important to investigate whether the health insurance product discourages SKS clients from renewing, or selectively encourage some types of client to renew.

We compared the renewal rate (i.e. the take up of a new group loan for client finishing their first group loan) in treatment and control center. The renewal rates are high, and similar in treatment and control groups. 96% of clients take up a new group loan in treatment centers, and 95% do so in comparison centers. The results are similar when we restrict the data to our baseline (94% in treatment and 95% in control, respectively). This is encouraging on two counts: first, it suggests that the health insurance product is not affecting SKS core business. Second, since the renewal rates are so high, it implies that SKS can effectively cover and keep covered a large number of lives.

It could still be the case that the few clients who drop out are different in the treatment and control groups. We thus compared the difference in a number of characteristics between those who renew and those who did not renew in treatment and control groups. A number of measures of health were created to capture different aspects of health which might explain a client's choice to take up the insurance product. These measures include the number of consultations in the last month, total household spending on health in the last month, an index of chronic disease, an index of self-reported health, the number of health conditions reported by adults in the household during the last month, and the number of adverse health shocks in the last year. When each of these health measures are included in the analysis, we do not find a statistically significant difference in enrollment rates between the treatment and control group for these measures of health. There is thus no evidence so far that the health insurance lead to adverse changes in the composition of SKS clients

Policy implications:

- Households experience frequent and costly health shock, which often result in financial jeopardy. There is thus scope for health insurance to lead to considerable improvement in their health and financial stability. This could in turn become beneficial to the microfinance organization if it helped client repay their loans and maintain a healthy business.
- Health insurance does not lead to a change in the rate of renewal of the composition of the clients who renew their loan: providing health insurance does not negatively affect SKS main business, and SKS is able to insure a large number of clients at a very small administrative cost: Microfinance institutions are thus likely to be an effective channel to providing health insurance.
- The evidence shows that insurance can be provided to poor populations without necessarily entailing adverse selection. Coupling insurance with other much needed products that the poor lack

access to may be a promising mechanism for reducing adverse selection and ensuring the sustainability of insurance schemes.