

Provision of health services for microfinance clients: Analysis of evidence from India

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ABSTRACT

Microfinance has proved to be an effective and powerful tool for poverty reduction. There is a greater reduction in poverty when microfinance programs are combined with increased access to basic social services, including health, than when the programs focus on credit alone. Studies have shown that illness and related expenditures are the leading cause for micro-business failures and loan default. This paper is an attempt to understand the health programs offered by MFIs in India, and build the case for wider integration of health into microfinance programs.

A review of MFIs listed in the MIX Market database was done, followed by a search of individual MFI websites. One in every four MFIs in India offers some form of health services. These programs vary widely from small scale health awareness programs to complex health interventions. Health education is the most common health intervention by MFIs (58%), followed by health camps (24%), and health insurance (24%). 12% MFIs offer health loans in addition to the regular business loan. 38% of MFI-health programs attempts to address composite health needs of their clients. 11% of the MFIs addresses the issue of community hygiene and sanitation and nutrition, followed by awareness and control of HIV/AIDS, mother and child health, and immunization program (8%).

Often MFIs struggle to design appropriate community sensitive health programs which can result in failures. Also the lack of evidence sharing in the sector, calls for more systematic efforts to strengthen evaluation and applied research.

INTRODUCTION

Microfinance, the extension of small loans to groups of people for the purpose of investing in self-employment programs, has proved to be an effective and powerful tool for poverty reduction. Evidence shows the positive impact of microfinance on poverty reduction as it relates to the first six out of the eight Millennium Development Goals.¹ Over 3,500 microfinance institutions (MFIs) provide microcredit and financial services to more than 155 million households worldwide, according to the Microcredit Summit Campaign. Conservative estimates indicate that at least 34 million of these households are very poor by the Millennium Development Goals definition, representing 170 million people, often living in remote and hard-to-reach locales.

Of these poorest clients, 83.4 percent, or 88,726,893, were women. Approximately 90.1 percent of the poorest clients reported were in Asia, a continent that is home to approximately 63.5 percent of the world's people living on less than US\$1 a day.² The reported loan repayment rates, even among the poorest clients, often exceed 95%.³ The microfinance industry is increasingly becoming part of the larger financial framework and microfinance institutions (MFIs) are emerging as social businesses within this framework, catering to an untapped market segment while creating value for their members, through access to low cost financial services.

However, provision of credit alone cannot mitigate poverty. A poor woman who generates income through microfinance but does not have adequate access to health care for herself and her family is still living in poverty associated with poor health. There is a greater reduction in poverty when microfinance programs are combined with increased access to basic social services than when the programs focus on credit alone.⁴ The unmet demands as well as the social and business rationale for microfinance institutions (MFI) to diversify into provision of health services are discussed in the following sections.

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INTEGRATING HEALTH INTO MICROFINANCE PROGRAM

There are multiple arguments for integrating microfinance and health services. At a macro level, Microfinance is poised to become an effective tool to address the growing public health concerns for developing economies with 3 out of 8 Millennium Development Goals directly relating to health;

- i. Reduce child mortality: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate
- ii. Improve maternal health: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio
- iii Combat HIV/AIDS, Malaria and other diseases: Have halted by 2015 and begun to reverse the spread of HIV/AIDS.

There is a strong business rationale for integrating health services into microfinance program. Among Grameen Bank clients, illness and related expenditures are the leading cause for micro-business failures and loan default.⁵ A study among self help groups in two districts of Kerala, India found that out of 2338 loans taken during 2005- 2006, 11% were taken for health care purpose.⁶ Other benefits of integrating health services into microfinance include economic empowerment, social empowerment, and reduced gender based violence. One of the rare randomized control trials in the area⁷ demonstrated the impact of microfinance-based intervention on women's empowerment and the reduction of intimate partner violence in South Africa.

A number of microfinance programs have sought to provide additional inputs to their financial products such as basic health services, health education, or health insurance products. Such integrated packages may provide both the means (income/empowerment) and the knowledge to address priority health concerns, and present the possibility of substantial cost recovery for microfinance providers (through interest charges and fees for other services), allowing broader reach to target groups.⁸ Leatherman and Dunford⁹ in reviewing evidences observed that adding health education alone, usually delivered during the routinely scheduled microfinance group meetings, improve knowledge that leads to behavioral change. These behaviors are associated with positive health outcomes in diverse areas that are critically important to achieving the MDGs, such as maternal and child health, and infectious disease. Health programs by microfinance institutions have positive impact on under-nutrition and diarrhea, which are the most common causes of illness and childhood deaths in the developing world.^{10,11} From the business perspective, a number of studies have demonstrated the effectiveness of combining microfinance and other development tools in increasing

client outreach (i.e. the more clients it serves) and maximizing benefits to the clients of MFI.^{12,13,14} A 15 month microfinance and health integration pilot project in southern India by Freedom from Hunger in partnership with the Microcredit Summit Campaign and with financial support from Johnson & Johnson, demonstrated that MFIs were willing and able to pay for health education training that expanded client services and improved clients' health.²

TYPES OF HEALTH SERVICES BY MFI

Microfinance organizations have experimented with different types of health programs depending on their client needs and institutional strategic interests. Programs range from preventive to curative services. Prevention includes promoting health awareness, education and advocacy to provision of health insurance; health loans, and savings. Curative services include home based health services as well as formalizing linkages with public and private healthcare providers. Different models of health provision exist. While in some cases MFIs have formally contracted with healthcare providers to provide services to their clients^{15,16,17} in other cases they have set up a specialized agency within their own structure to directly deliver health services.¹⁸ Multilateral and bilateral agencies as well as philanthropists like UNFPA, USAID, ILO, Bill & Melinda Gates Foundation supported MFIs to diversify, adding health to their portfolios.^{2,16} Technical support agencies like Freedom from Hunger have implemented projects to demonstrate the effectiveness of providing health services in conjunction with microfinance programs.^{2,19} Table 1 provides an example of the suggested approaches MFIs can adopt to address client needs.

HEALTH AND MICROFINANCE: INDIA SCENARIO

Seven MFIs from India has made their place in the 2007 Forbes first ever listing of top 50 MFIs worldwide. The MIX MARKET provides information on 1812 MFIs catering

Table 1: Health Program options to suit client needs

| Client Needs | Examples of Intervention |
|---------------------------------------|--------------------------------------|
| Cash to cover health expenses | Health savings and/or Health loans |
| Access to affordable medicines | Linkages to health product providers |
| Need for competent health workers | Linkages to healthcare providers |
| Access to predictable health coverage | Prepaid health insurance plans |
| Knowledge of good health practices | Health education |

Source: Adopted from Freedom from Hunger

to 496.5 million clients.²⁰ 134 MFIs are reported from India in 2009 with a gross loan portfolio of 14.3 billion USD. A detail web search of MFIs which reported “health” in their Products and Services shows 37 (25%) of the Indian MFIs as offering some form of health services. These programs vary widely from small scale health awareness programs to large and complex health programs with provision of clinical services. While population reached specifically through the health program is not available, together the 37 MFIs reach out to 28 million borrowers in 2008-09. Impact of the health program was not explored.

Health Programs

The type of program most commonly offered to meet health needs is health education sessions (58%). Other health-related programs offered by MFIs include health camps (24%), and health insurance (24%). 12% MFIs offer health loans in addition to the regular business loan. Additional interventions mentioned include slum

health, capacity building, community pharmacies or dispensaries, contracts with providers, hospital services, and telemedicine. While some program goals are meant to address a single health need, such as treatment of tuberculosis or HIV/AIDS, other programs are meant to address broader goals by providing a bundle of services (Figure 1).

Health Needs

Web search on health needs addressed by the MFIs shows 38% of MFIs offer composite health needs of their population. Among those, which offer single health need, 11% of MFIs program addresses the issue of community hygiene and sanitation and nutrition, followed by awareness and control of HIV/AIDS, mother and child health, and immunization program (8%). The following health needs were also addressed by a smaller numbers: adolescent health, tuberculosis, mental health, leprosy, ophthalmic issues, and deworming.

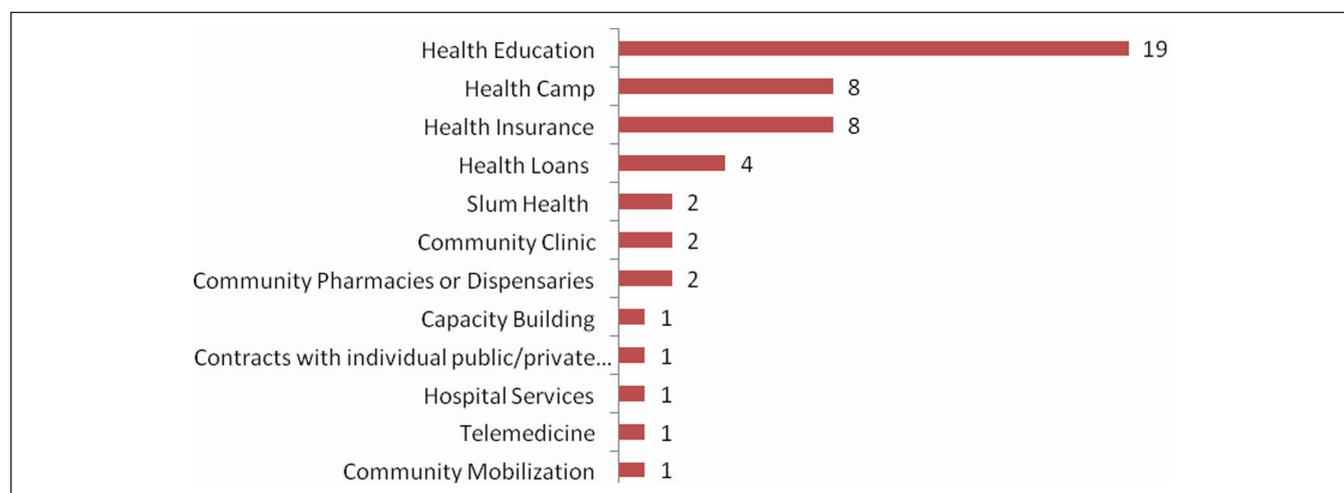


Figure 1: Health Programs Addressed Number represents MFIs (N = 37)

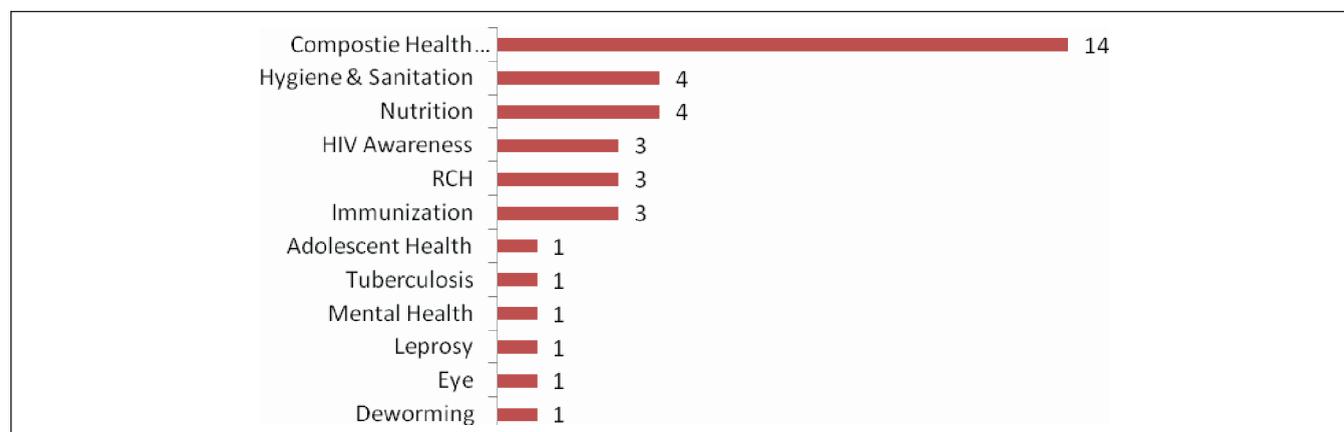


Figure 2: Health Needs Addressed Number represents MFIs (N = 37)

PRACTITIONERS PERSPECTIVE ON OFFERING HEALTH PRODUCTS

Under most of the credit programs, loan entitlements are limited to loans for productive purposes. Human development investments like education, healthcare are considered as consumption expenditure and so not usually considered as loan entitlement categories. With this concern, a discussion in the Solution Exchange online community highlighted the following insights:

1. MFIs consider loans for education and health purposes as not 'consumption loans' rather they are long-term investment loans, which do not produce (cash inflow) in a short span of time.
2. However, MFIs are wary of high risk and experimental cost involved in developing health and education oriented microfinance (MF) products and services. There is a need to understand that investing in the social sector, through credit plus approach, would enable their clients to address health and education problems and progress towards a higher level of well-being, which would eventually translate into an enhanced ability to absorb credit. Further, if MF clients are made aware of better utilization of loans and surplus amount generated out

of the 'productive' use of the micro-credit, they may start investing in health and education.

3. MFIs generally provide health and educational loans based on a 'judgment' i.e. MFIs lack well-developed independent products with defined eligibility criteria, repayment structures, product features, loan appraisal techniques, and differential interest rates. Besides, MFIs find it difficult to control clients' borrowings from various sources and monitor their end utilization.

CONCLUSION

An unpublished research note²¹ observed that MFIs that offer health programs are committed to meeting client needs; however, most do so with some concerns about sustainability. In India a growing body of MFIs sees the business and social rationale in offering health as part of their portfolio. However, impact of such health program in the long term sustainability of MFIs core business is important to make a sound business case for MFIs to invest in health services.

Many questions remain as to the most viable and effective approaches for integrating microfinance and health access strategies. Often MFIs struggle to design appropriate

Box1: MFI linked health programs in India

Health Savings

- *Ibtada*, a NGO in Alwar helps women members to meet their **health and education expenditures** through inculcating the habit of internal savings. These savings are supposed to meet their predictable needs for marriage, education, festivals etc. Presently almost 2,000 members have saved more than Rs. 28 lakhs.
- In 1988, *Mahila Samakhya* was launched to provide conceptual and practical links between women's empowerment and education. The programme is currently being implemented in over 9,000 villages in ten states. The federations formed under this program, formulate their own rules of operation on the need for investment in **health** and education. Some groups have chosen to give 20% of their own savings as interest free lending for these purposes.

Health Loan for Medical Emergencies

- The Indian Association for Savings and Credit operating has four broad categories of well-defined micro-credit products. Under one of the four loans category, it offers loans for education (maximum loan size Rs. 25,000 for up to 3 years) and **medical emergencies** (maximum loan size Rs. 5,000 for up to 2 years). It also offers loans for constructing latrines (maximum loan size Rs. 7,500 for up to 2 years).
- Besides loans for income generation and asset development, SKS India has a loan product called *Raksha* (Emergency Loan) which is given to meet **health**, funerals and hospitalization related expenses. It provides such loans for the maximum period of 20 weeks payable in lump sum without any interest rate. The MFI provide **emergency health loans** along with loans for healthcare services and education. The MFI disbursed the first health loan

on February 2007 worth Rs. 25,000 among five members for surgical and treatment purposes.

- *Pradeepan* is an NGO based in Betul district working to improve the standard of living for the poor. It provides micro-credit to SHG members at a monthly interest rate of 1% for the poor to meet their **health and education expenses**, as compared to 2% interest on loans for other items.

Health Insurance

- *SEWA* first became actively involved in the public health field in the early 1970s through health education and provision of maternity benefits. The *SEWA Health Team* provides a wide range of primary health care services, but the main thrust is to provide simple, life-saving health information with a focus on disease prevention and promotion of well-being. In 1992, *SEWA's* Integrated Social Security Scheme was initiated with coverage for life, asset loss, widowhood, personal accident, sickness and maternity benefits. In 2002, medical insurance for husbands of members was added to the scheme, and in 2003, the scheme extended health insurance cover to children of members.
- *Ujjivan* launched a **microhealth insurance** product with one of the major insurance companies in India in June 2007. However, the quality of service by the primary provider (hospitals) was way below standard and *Ujjivan* had to close it down in July 2008.

Provision of Services

- *Kadamalai Kalanjia Vattara Sangam*, promoted by *Kalanjiam Foundation*, is an autonomous and financially self-sufficient federation of SHGs at *Mayiladumparai-Kadamalaikundu* block in *Theni* district. Having identified the huge need among its members for proper **maternity healthcare services**, first, it appointed **traditional birth attendants** and then it set up a **hospital** able to serve patients (served 270 SHGs as of March 2005) from 15 villages of the block.

community sensitive health programs which can result in failures. The struggle and instances of failure of MFIs in designing appropriate community sensitive health program was highlighted as²² “... for every successful example of a micro-insurance product (linked to MFIs) there are several examples of spectacular failures that often leave clients without a protection (despite having paid their premiums) and the providing institution bankrupt.” This underlies the necessity to build effective technical capacity in program design and implementation. Also the lack of evidence sharing in the sector, calls for more systematic efforts to strengthen evaluation and applied research. This observation is corroborated by two recommended actions by UNFPA²³

- a. identify, collaborate with and support institutions – both practitioners and international technical assistance providers;
- and b. Organize donor symposiums on the topic featuring leaders from a variety of institutions.

Active support from donor and technical support agencies is required in the initial phase to check for design failures. Along with demonstration of positive health outcome, benefit cost analysis and scenario analysis to project the investment and return (in terms of reduction in loan defaulter and thus micro-business failure) from health intervention will help MFIs take more informed business decisions. Such scenario analysis need to address the best package of health interventions an MFI can adopt for a given client base, loan repayment rate, and priority health needs.

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