STUDY SUMMARY

Providing Health Insurance Through Microfinance Networks in Rural India

Policy Issue

For struggling families living in poverty, economic shocks can be devastating. An unexpected home or equipment repair, loss of income, or ailing family member can drain money needed for food and housing. Health shocks are among the largest and least predictable forms of uncertainty that a poor family can face. In developing countries, high levels of poverty and poor health conditions have the potential to make health shocks all the more frequent and dangerous. Formal health insurance has the potential to mitigate the impact of health shocks.

Evaluation Context

Karnataka is one of the more economically progressive states in India, but much of the rural population still lives in poverty. Despite the burden imposed by health shocks, only 1% of households in rural India are estimated to have formal health insurance policies. There is little systematic evidence on effective distribution networks or the benefits of access to affordable health insurance.

RESEARCHERS
Abhijit Banerjee, Esther Duflo

COUNTRY
India

PARTNER
Centre for Micro Finance at the Institute for Financial Management and Research

PROGRAM AREAS
Financial Inclusion, Health

TOPICS
Insurance, Microcredit

TIMELINE
2007

Launched in 1998, Swayam Krishi Sangam (SKS) Microfinance is one of the fastest growing microfinance organizations in the world, having provided over $92 million in loans to female clients in poor regions of India. Borrowers take loans for a range of income-generating activities. In 2007, SKS Microfinance piloted a mandatory health insurance policy for microfinance clients in rural Karnataka. The policy charges a $5 – $10 premium in exchange for $200 – $400 of coverage for hospitalization, maternity, or personal injury.

Details of the Intervention

This research project evaluates SKS Microfinance's pilot health insurance program. SKS identified 201 villages where it was running its microfinance program and was willing to pilot its new health insurance program. From this group, the researchers randomly selected 101 villages to receive the health insurance program in the summer of 2007. The other 100 villages serve as a comparison group.

Using survey data from 5,500 randomly selected households in these 201 villages, the analysis will focus on three main topics. First, whether the program improved health outcomes and the ability of clients to repay loans. Second, to what extent the economic lives of the poor are affected by health shocks, with and without formal health insurance. Third, whether using microfinance as a way to distribute health insurance helps avoid adverse selection and moral hazard, which could undermine

the sustainability of a health insurance system.

Household and adult surveys, prior to the insurance rollout and two years after, will gauge changes in household and individual outcomes. In addition, running surveys collect targeted information related to births and infrequent major health events. The running surveys provide a rare opportunity to observe households' immediate reactions to these shocks, and compare those against households' long-term adjustments.

Results and Policy Lessons

Preliminary findings from the analysis of baseline data reveal considerable unmet demand for insurance. Less than 1% of households have accident or health insurance, but they face frequent and serious health shocks. The average health shock cost Rs. 1,900, while the average per-capita monthly expenditure was just Rs. 708. Households often paid health expenses using a high-interest loan from moneylenders. The data suggest that SKS households, despite being members of a microcredit organization, face considerable financial risk from health shocks. Bundling catastrophic health insurance with microfinance has promise to alleviate this risk.