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CMF PROGRESS BRIEF

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An Impact Evaluation of the Provision of Health Insurance Through Microfinance Networks in Rural India

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BACKGROUND

Health shocks are among the biggest and least predictable forms of uncertainty that a poor family faces (Gruber-Gertler 2002). For households without insurance or access to credit, periods of poor health may sharply lower consumption in the short-term (Townsend 1994) or decrease investments in very productive assets (Rosenzweig and Wolpin 1993). The World Bank 2004 World Development Report discusses this as a potential endemic source of poverty: "Illness pushes households into poverty, through lost wages, high spending for catastrophic illnesses, and repeated treatment for other illnesses."

Despite households' great need for mitigating the effects of health shocks, only 1% of households in rural India are estimated to have formal health insurance policies. The provision of formal health insurance is likely limited by the traditional concerns of health insurers, namely avoiding superfluous or fraudulent claims and an adversely-selected group of clients – concerns which are often heightened in the developing world. There is very little systematic evidence, however, on how the rural poor might respond to the availability of health insurance. Just as loans were once thought to be infeasible, there has been little expansion of health insurance into these areas.

This study explores three main aspects of this potential market for health insurance: how much the rural poor benefit from insurance, what challenges insurance providers face, and what distribution mechanisms might be effective. These insights will help improve private health insurance products, help design public policies to assist private providers, and help design more effective public health programs. By explicitly analyzing the incentives of health insurance consumers and providers, the goal is to assist the establishment of self-sustaining insurance for the rural poor.

PROGRAM DESCRIPTION

Launched in 1998, SKS Microfinance is one of the fastest growing microfinance organizations in the world, having provided over $92 million and has maintained outstanding loans of $38 million to over 320,000 female clients in poor regions of India. Borrowers take loans for a range of income-generating activities, including livestock, agriculture, trade (such as vegetable vending), and production (from basket weaving to pottery). SKS also offers interest-free loans for emergencies as well as life insurance to borrowers.

In 2008, SKS Microfinance is going to introduce a mandatory health insurance policy for its microfinance clients. The policy charges a $5 – $10 premium in exchange for $200 – $400 of coverage for hospitalization, maternity, or personal injury. Premiums vary depending on the level of coverage and how many family members are included. Their working draft of the coverage options and details is attached to the end of this document.

SKS plans to collect the insurance premium and pass its clients' health risks onto a third-party insurer,

allowing it to focus on the administrative aspects of the program. This is standard in the insurance industry, but SKS should be able to leverage its existing microfinance infrastructure to assist in the administration.

RESEARCH DESIGN AND ANALYSIS

Beyond identifying the effects of health insurance and consumers' responses, the research project provides a case study for this particularly promising mechanism for insuring the rural poor in developing countries.

In 2007, SKS will pilot the program in roughly 100 villages. SKS has identified 201 villages where it would be willing to pilot the program. CMF and J-PAL have randomly selected 100 villages where SKS will attempt to begin the pilot project, and 101 villages where SKS will not do the pilot project. CMF and J-PAL will collect survey data in these villages to address a range of issues. The first set of research questions correspond to how poor rural households respond to negative health shocks in the absence of formal health insurance. Households may respond by lowering consumption or by selling assets that are used primarily for consumption or production. Households may obtain loans through formal financial sectors or may rely on more informal social networks for loans or gifts. Other members of the household may work more, particularly children that may be taken out of school.

Baseline survey: The basic data for this project will be collected in two rounds of surveys given to approximately 30 households in each of 201 villages in the Gulbarga and Bidar Districts of Karnataka, India on economic status and assets, means of livelihood, household expenses, eating habits, health status, and household composition. Each adult will also be surveyed on their own characteristics, including their means of livelihood, income, educational background, expenses, health status, and medical treatment patterns. One parent will be asked a smaller set of questions about their children. When new clients join SKS, some will be randomly chosen to receive the baseline survey, in order to determine whether different clients are attracted by the health insurance program. The Baseline survey is expected to be completed by April 2007.

Endline survey: After one year, the same individuals will be given a second survey to gauge changes in household and individual outcomes. Financial data from SKS and health data from the insurance provider will be merged to this dataset. Depending on the continuation of the project, additional surveys beyond one year may be administered.

Running survey: In addition, we will conduct a running survey that collects targeted information whenever these low probability events occur in the 236 villages. The two sources of data would strongly complement each other. This running survey would also provide a rare opportunity to observe households' immediate reactions to these shocks and compare those against their long-term adjustments.

CONTRIBUTIONS

Despite recognition of the need for health insurance, there is little evidence on how the rural poor would respond to its availability. By analyzing the randomized introduction of health insurance to microfinance clients in rural India, this project provides a direct window into the ability of poor households to adjust to health shocks. Randomization is a well-known tool, but its application to health insurance in a developing country is pioneering.

The project also evaluates and refines an innovative mechanism for distributing insurance: leveraging existing microfinance client networks. The ability of microfinance organizations to efficiently manage small loans is well-established, but it is unknown whether they would be similarly effective in administering health insurance. The study will examine whether SKS's clients remain when they must purchase health insurance and whether this method mitigates adverse selection. This presents a model for replication wherever microfinance has been successful, as well as providing information to improve or tailor the program design.