Protecting health: thinking small

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Box 1. Characteristics of microfinance institutions

- The amount of each loan is relatively small (typically US$ 50–1000) shielding the institution from large single losses.
- The term of loans is short (usually a few months), allowing greater flexibility in terms of which sectors and individuals receive loans.
- Interest and capital are repaid in a large number of small instalments, allowing close monitoring of clients for potential distress.
- Banking officials often visit the customers helping to establish personal relationships, maximizing repeat borrowing.
- Decentralized decision-making allows for quick loan-making decisions and enables loan makers to respond quickly to changes in borrower or overall market conditions.
- Group lending and solidarity groups further dissuade users from defaulting on loans.

Benefits of microfinance

When illness strikes, people on low-incomes often respond by foregoing their children's education, selling limited assets (including those used to make a living), borrowing from informal sources at exorbitant rates or foregoing medical treatment. Limited access to formal credit and savings arrangements constrain health-care financing options for these people. In low-income countries, private sources (including out-of-pocket expenses) account for more than 60% of health-care expenditure; 20% more than in upper-middle and high-income countries.[1] With such a high percentage of health care financed privately, residents of developing countries are particularly vulnerable to financial instability from "health shocks" (i.e. new and significant health issues).

Microfinance has been successfully deployed to compensate for the lack of traditional financing opportunities in developing countries.[2] It can also be used to help finance health care for excluded populations. Microfinance broadly refers to small loans, savings opportunities, insurance and other financial products and services tailored for poor people. The most common tool, microcredit, is the extension of small loans, often without collateral requirements, usually for self-employment projects that generate income. By capitalizing on social networks in poorer communities and developing channels into the informal economy, microfinance is assisting millions of people, particularly women, to improve financial resilience.

Additionally, by promoting local entrepreneurship, microfinance helps build a more resilient and secure local economy. This resilience is demonstrated in a review by the Inter-American Development Bank of the recent global recession, which indicated that industry leaders in microfinance matched or even outperformed their commercial bank counterparts in key performance indicators.[3] Box 1 shows additional characteristics that promote the economic resilience of microfinance institutions. Due to its success in providing conventional financing for poor communities, microfinance is now being used as a tool for health financing and also health education and prevention.

Health promotion and education

Several microfinance programmes have incorporated preventive health education as part of services based on either public service motives or from the belief that health education will lead to higher repayments, client retention, and increased profit. In South Africa, for example, the IMAGE (Intervention with Microfinance for AIDS and Gender Equity) project combined a microfinance programme for women with HIV and gender training curriculum. The results of a randomized control study indicated that a microfinance and training intervention resulted in a > 50% reduction in intimate-partner violence among programme participants.[4] Furthermore, after two years the study showed an improvement in nine measures of empowerment, including self-confidence and financial confidence. Other research has shown that improvements in women's income through microfinance projects led to advancements in preventive health care. Improvements in nutrition, immunization coverage, contraceptive use and other health measures have been demonstrated in communities using microfinance.[5]

In addition, microfinance has been used for infrastructure development. In Lesotho, for example, under a United Nations and World Bank programme, poor families were given credit for purchasing and installing latrines in their community, after depositing a portion of the costs in a bank. Leveraging household and community resources for sanitation improvements have also been reported in many other countries

Can it benefit the poorest?

Despite the strengths of microfinance, it has thus far been largely inaccessible to the absolute poorest communities. The poorest communities continue to depend on public spending and donor aid, unable to benefit from microcredit or microsavings because of an absolute lack of capital. Microfinance may alleviate some financial burden on the public sector by providing coverage for some of these people, but its ability to provide for extremely poor people is still under investigation.

BRAC, one of the world's largest nongovernmental organizations with extensive microfinance capabilities, has targeted the "ultra poor" with a package including health-care subsidies, training, interventions for social inclusion and even cash subsidies. A recent evaluation by the Asian Development Bank of this

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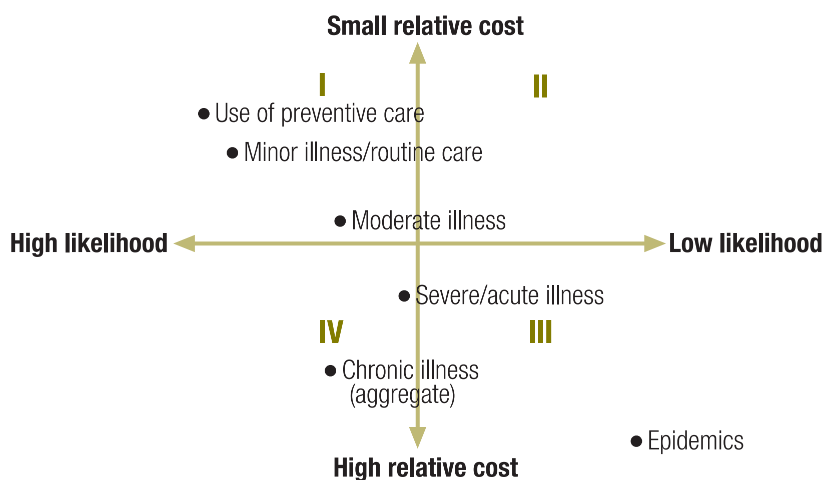
(*Submitted: 31 August 2009 – Revised version received: 13 January 2010 – Accepted: 13 January 2010 – Published online: 3 June 2010*)

Fig. 1. **Cost and likelihood of health-care needs**



programme indicated that these broad interventions have led to improved economic and health outcomes for the poorest participants.

Microfinance for health

Choosing the appropriate microfinance tool (credit, savings or insurance) for the health-care need is challenging and, in many cases, evidence is lacking for making informed decisions. The choice of which instrument to use can be considered a function of two variables: (i) the likelihood of the health-care event, and (ii) the relative cost of the event (Fig. 1). Under the likelihood of the health-care event variable, one must consider duration and frequency of the event. The costs associated with the event can be recurring (chronic diseases) or infrequent (certain epidemics). With these variables, one can create a framework for choosing the appropriate financial tools for each type of event.

Microcredit and microsavings may be best suited for relatively lower cost health-care services, including some acute events and preventive care. As costs increase, however, relative to a household's savings or expected future income, savings and credit products become increasingly less attractive solutions as neither can effectively provide full protection against losses greater than what a household can save or repay in the future. Micro-insurance (namely voluntary, contributory, risk-pooling endeavours designed to address the needs of the poor) then becomes a more relevant method to guard against risk as the size of potential loss increases. Given that micro-insurance schemes operate within a local community, this community is likely to be exposed to many of the same risks (e.g. natural disasters, epidemics, social insecurity). A key role for international institutions is to explore strategies for better distributing localized risk, thus allowing micro-insurance to serve populations when it is most needed. Savings and credit tools may be more applicable for quadrants I and II in Fig. 1, as these expenditures have the best chance of being affordable for savers or loan takers. However, as costs increase in quadrants III and IV, insurance becomes a more realistic way to finance health, since the potential loss may be too high to be financed through savings or credit.

At extreme levels of uncertainty and cost (quadrant III), insurance generally becomes a less effective tool to manage risk. As a result, most mass, covariant risks, such as certain epidemics and natural disasters, can be difficult to insure, particularly for the relatively smaller micro-insurance organizations. For these types of situations, government relief and aid from the international community are alternative sources for partial coverage. The largest potential for microfinance is seen for addressing idiosyncratic risks, such as those related to basic health and disability. As microfinance institutions grow and increase their outreach, they may also increase their potential to help their clients address larger, covariant risks.

Microcredit and microsavings offer potential for providing predictable, low-cost health care where it otherwise may not have been accessible. Micro-insurance could supplement public medical plans in poor, underserved areas. There are varying health-care uses, strengths and weaknesses of these microfinance approaches for health (Table 1). Micro-insurance, by offering greater protection than a household may save or borrow, offers significant promise.

Microfinance to help fund health certainly has limitations that need further investigation. Some of the areas that need further investigation include access to extremely poor people, difficulties in targeting the right form of microfinance to match other social factors in a community and ability to expand schemes. Critically, microcredit and microsavings schemes do not solve the issue of out-of-pocket payments deterring access to health care. Like user-fees, microcredit and microsavings for financing of health services are unlikely to improve health equity. Certainly, more trials are needed to evaluate the potential health benefits

Table 1. **Strengths and weaknesses of microfinance tools for health**

Microfinance tool	Health-care use	Strength	Weakness
Microcredit	• Low cost, predictable health care (quadrants I and II), including: preventive care, maternal health and delivery, minor surgery, injury care. In addition, health promotion can be tied to non-health microcredit	• Avoid exorbitant interest rates of lenders	• May deter usage of health care • If dependent on foreign debt, vulnerable to exchange rate shifts
Microsavings		• Avoid disruption to health-care access during economic downturn or with moderate illness	• May deter usage of health care
Micro-insurance	• Low probability, costly health care (quadrants III and IV); usually supplements public medical programmes	• Risk-pooling	• At extreme levels of cost, cannot manage risk; especially when risks are regional (e.g. epidemics, natural disaster)

of microfinance. Additionally, studies on repayment rates for microcredit used for health-care financing are needed.

A comprehensive study of plans that cover different types of care (e.g. hospitalization only versus inclusion of outpatient care), various re-insurance schemes to cover broader risks and better assessments of risk in poorer populations are all needed to ensure optimal insurance services. In addition, concerns about high interest rates in some schemes and the commoditization of social capital must be considered. Research on the benefits and limits of all forms of microfinance should be promoted and conducted by governments, nongovernmental organizations and microfinance institutions to make informed choices within different sociocultural contexts.

International organizations such as the World Health Organization and The World Bank should continue to make microfinance for health a consideration in technical advice given to governments on health-care financing and social protection. They should also fund systematic, evaluative research so that science can back up what seems to be a logical and useful approach to health-care financing for the poor, particularly as it emphasizes prevention and health promotion. The large-scale delivery of these tools will depend on repeated local adoption that must grow from communication of demonstrated success and advice on implementation of effective models. However, we already have enough knowledge to recognize that microfinance is an important tool in protecting health. Given the grave risks to health from the current economic crisis, governments, international institutions and nongovernmental organizations must consider microfinance when shaping their policies to finance and promote health during these difficult economic times. ■

Competing interests: None declared.

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