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Shaping national health financing systems: can micro-banking contribute?

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A major global health financing challenge is to develop national health financing systems, particularly in low- and middle-income countries, that protect people against financial catastrophe and impoverishment associated with paying for health services.

Domestic resources, despite the increased external assistance since the Millennium Development Goals (MDGs) were agreed in 2000, still contribute about 75% of all funds for health in a typical low-income country, a percentage that can be as high as 99% in some low- and middle-income countries. Out-of-pocket payments (OOPs) made by patients directly to providers account for nearly 70% and 50% of total health expenditure respectively in low- and middle-income countries. Often financed through distress selling of assets, high-interest loans from local money lenders, and borrowing from relatives/friends, OOPs prevent many people from seeking/continuing health care besides imposing catastrophic financial burden and poverty on some of those who seek care. It is estimated that around 150 million individuals suffer severe financial hardship (and 100 million pushed under the poverty line) each year simply as a result of seeking care and having to pay for health care services they receive.[1] These figures, however, exclude people who suffer financial hardship because they are unable to seek care and suffer extended period of ill-health as a result. Within countries, the risk of severe illness, early death and financial catastrophe linked to high OOP is highest among the poorest sections of the populations.

New financing strategies are now emerging to mobilize additional resources for health and provide incentives for spending the existing resources wisely. Micro-banking is being explored as an option to manage financial risk and protect people against the financial consequences of seeking health care in a number of countries. The purpose of this technical brief is to discuss the scope and potential of micro-banking in health.

What is micro-banking?

Micro-banking is often discussed along with micro-insurance and other financial products for the poor under the umbrella of 'microfinance'; micro-insurance will be part of a forthcoming Technical Brief so is not discussed further. Here, we focus on micro-banking, a broad term generally referring to small loans (micro-credit) and savings (micro-savings) opportunities for the poor and other disadvantaged populations such as women. It provides affordable access to banking services by linking such population groups with the formal banking sector. In doing so, it can help to empower them to control their own lives.

The most common micro-banking tool is micro-credit, which extends small loans, often without collateral requirements, to impoverished people. First explored in Bangladesh in

[1] *See Technical Brief No.2, 2005 for further details.*

1976 when the *Grameen Bank* project was established, micro-credit substitutes 'borrower collateral' with 'social collateral' through peer pressure support using small informal groups (largely female) to ensure repayment. However, many micro-banking institutions now use individual liability, with evidence showing equal effectiveness in individual and group liability schemes. The essence of micro-credit lies in its low-cost procedures replacing sophisticated credit-evaluation techniques and collateral regulations. Loan interest rates (18-61% per annum), while seemingly high by commercial credit standards, are generally significantly below the rates (reportedly 36-5,000%) charged by informal credit sources such as money lenders in the same settings.

Box-1: An example of micro-banking

Credito con Educacion Rural (CRECER), a group-based lender in Bolivia, uses village banking comprising groups of 15-20 members to offer integrated financial and education services to poor women in rural and marginal urban areas for bettering their health, nutrition and economic status. Loans, repaid in 16-24 weeks, are given to the group, which then divides the funds among its members. Village banks meet every 1-2 weeks during which members repay loans and make deposits. Members are also trained on a variety of health topics (women's health, breastfeeding, integrated management of childhood illnesses, infant and child feeding, etc.). In some places, CRECER also established contacts with rural health care clinics to offer clinical health services.

As of September 2005, CRECER had 4,306 village banks serving 68,748 members with savings worth US$ 3.24 million and outstanding loans worth US$ 12.46 million (mean loan size US$ 150 per borrower). About 23% of the clients were reportedly in the poorest population group, 50% were moderately poor, 21% were at the threshold and 6% were non-poor.

Micro-saving, developed in the 1990s, allows people to deposit money in small amounts for future use, without minimum balance requirements and often in conjunction with credit. Saving by the poor often comes in such small increments that conventional banks are not prepared to offer services to them, either because the transaction costs are deemed unprofitable or because of other more lucrative investment opportunities.

A review of data from 47 countries reveals that micro-banking services are provided by large networks of development banks, big institutions (each reporting more than 100,000 clients) and numerous small institutions. The first two categories of institutions, which are either state-sponsored or not-for-profit institutions, meet about 90% of the demand, particularly from the poorest population groups. Some institutions, primarily engaged in other businesses, extend micro-banking as a means to generate community goodwill so as to enjoy competitive edge through the banking-health linkage. Altogether, micro-banking resources constitute about 2.5% of total banking resources.

How relevant is it to health financing?

Given its ability to reach out to a section of disadvantaged households, micro-banking could be used as an institutional financing mechanism for health. It does not change the need for patients to pay providers when they get sick, but micro-savings is a form of pre-payment. Micro-credit provides loans at relatively low interest rates that could be used to

generate income or be used to pay for needed services. In this way, micro-banking has the potential to make health services more accessible and to allow people to either save for future health needs, or to repay the costs slowly over time. By facilitating early case detection through timely financing of outpatient care, it could minimize the use of inpatient care thus reducing costs, and also allow people continue working.

Box-2: A *medisave* experiment among rural women in India

In 2007, a health financing experiment was conducted in the Indian state of Karnataka. One of the objectives was to improve rural women's access to essential health care, particularly outpatient care, in a sustainable manner. Built on the fact that many women saved informally, it linked this informal saving to formal banking with a greater potential to finance health care.

The process included a package of services including opening of an individual *medisave* account in the name of each enrolled woman, health insurance, health care provision, and community monitoring. Women's voluntary savings, an incentive in the form of a matching grant of up to US$ 1.80 per month, and the bank interest were the basic sources of outpatient care financing. In addition, for inpatient care, each enrolled woman, her spouse and two children were covered by a separate group health insurance scheme.

Enrolment was voluntary with approximately 50% of the target population choosing to enrol. About 80% of the enrolled women were poor, 70% were illiterate, and 70% had been designated (by government) as socially disadvantaged. Approximately 50% had also lacked autonomy prior to their enrolment to seek health care when needed.

Bank deposits along with the matching grant and bank interest were used to finance outpatient care after authorization while insurance was used for inpatient care. Bank records after one year showed that the average saving per woman was US$ 15 or 3.2% of their annual household income; saving per woman ranged between US$ 0.23 and US$ 4.53 per month. Total money generated for health care purpose including the matching grant and interest was US$ 27 (range US$ 0.45 - 46.02) per woman or 5.8% of their annual household income. This money was actually used to pay for 61.2% of their annual health bills on outpatient care.

Periodic documentation of their health care utilization (or non-utilization) revealed that 56% of the women's health care needs, including antenatal care, were met. Some women used the formal health care system for the first time and demonstrated to other comparable women that quality health care, including delivery care, was affordable. *Medisave* also helped to institutionalise some deliveries, which otherwise would have occurred at home.

Evidence on its possible impact on access to health care

Micro-banking is used for many reasons, one of which is to cover health costs. It is still evolving and the actual number of poor people linked with formal banking institutions through micro-banking is not yet clearly known. Estimates of the number of savings and

credit accounts with 'alternative financing institutions' in 2004 indicated the existence of about 650 million micro accounts serving about 500 million clients worldwide, with a predominant (84%) presence in the Asia-Pacific region. Demand side estimates indicate that micro-banking has so far reached between 2% and 13% of the target (i.e., the poor) population in different settings. The most recent estimate of the median size of a micro-loan per borrower ranges from US$ 99 (or 453 international dollars (Int.$) using purchasing power parity exchange rates that account for price differentials between countries) in the WHO South-East Asian Region to US$ 1,254 (Int.$ 3,120) in the European Region. These sums are considerably higher when the purchasing power of the loans is taken into account - see box-3.

Box-3: Median size of a micro-loan across WHO regions

WHO Region	Micro-loan size per borrower	
	US$	**Int.$**
African Region	203	779
American Region	636	1,428
Eastern Mediterranean Region	257	674
European Region	1,254	3,120
South-East Asian Region	99	453
Western Pacific Region	282	1,073

Little information is available of the proportion of micro-credit loans or of micro-savings incomes used to cover health expenditures. One of the few estimates comes from the example described in Box-2. The women in Karnataka saved an average of US$ 1.25 per month for health in 2007. Earlier studies had shown that they saved the equivalent of US$ 4.38 per month in total.

Some micro-banking schemes have been shown to improve access to health care services. For instance, the Human Development Report 2005 attributed Bangladesh's relative success in human development to micro-banking which had expanded economic opportunities, particularly for women, providing them with greater empowerment and choice. The specific influence of micro-banking was found in an increased use of contraceptives, pre- and post-natal care, trained providers for delivery, health promotion services and improved nutrition practices. Micro-credit clients in Bangladesh, for example, are 1.8 times more likely to use contraceptives than others and are likely to be less sick, possibly due to disease prevention efforts. Similar health improvements and health care benefits were also reported to be associated with micro-banking in Ethiopia. Elsewhere, micro-banking is also found to have enhanced access to health care by reducing health care exclusion rates.

Key considerations

Micro-banking has emerged largely as a community or NGO response to both market and government failures. Formal banks fail to provide services to poor clients, and governments are unable to ensure that needed services, including health, reach the poor. It is a promising way to allow the poor and disadvantaged to save, as well as to provide them with access to credit to improve their income earning potential. Indeed, it has become an important tool in the fight against poverty.

In terms of health financing, micro-banking can reduce the need for poor households to suddenly sell assets, or to take out loans at very high interest, to pay for care when they fall ill. It is, however, clearly not the preferred option of reducing the financial risks associated with ill health for a number of reasons. Firstly, micro-saving is a form of individual prepayment. There is no spreading of risks across the population, with the healthy subsidizing the sick and the rich subsidizing the poor. Secondly, micro-credit used to pay health expenses could also result in the need to sell assets subsequently to repay the loan - though micro-credit through formal banks is less likely to have this impact than credit provided by informal money lenders. Ideally, governments should be encouraging a move to greater prepayment and pooling across large population groups. They could use institutional mechanism newly created by micro-banking institutions as a vehicle.

This will, however, take some time in many countries. In the meantime, micro-banking is an important tool for poverty reduction, which has valuable positive side benefits in terms of offering greater access to health services.

A subsequent Technical Brief for Policy Makers will focus on micro-insurance.