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Sa-Dhan
The Association of Community Development Finance Institutions

Newsletter

From ED's Desk

We from Sa-Dhan are glad to share another issue of our newsletter. In the period since the last newsletter, Sa-Dhan had its Annual General Meeting at Bangalore in June. It was a huge success with the entire Sa-Dhan family rededicating itself to reach out financial services to the poorer sections of our society. Mr Aloysius Fernandez, one of the founding members of Sa-Dhan spoke at AGM's inaugural and took us all down the memory lane two decades back. Sa-Dhan collaborated with a French Business School, an Indian Business School and Sahulat Microfinance to organise an International Research Workshop on Microfinance, which contributed to a cross country understanding of issues in microfinance. The early data on the sector for 2015-16 points to a healthy growth despite Bandhan going out of microfinance space, which a positive harbinger. This issue of the Newsletter carries a writeup on community-based health insurance from one of our member institutions. This could be emulated by other institutions to expand the range of their financial inclusion services.

Industry Highlights

Microfinance sector has seen some positive changes during the Fourth quarter (January'16 to March'16) of the current financial year. The changes are as follows,

- Gross Loan Portfolio has increased by 20.12%.
- Net Loan Portfolio has increased by 13.64%.
- Managed Loan Portfolio has increased by 62.95%.
- Number of Active Borrowers has increased by 4.89%.
- Number of total staff has increased by 7.04%.
- Number of Loan officers has increase by 6.56%.
- 94% of Complaints made by clients have been resolved during this period.

(73 MFIs have reported and the growth is calculated as on 31st March over as on 31st December).

Evaluating health-seeking behaviour, utilization of care, and health risk: Evidence from a community based insurance model in India

Providing Community Based Health Insurance, CBHI, has been an idea gaining recent attention as a method to reduce vulnerability and increase access to health care in poorer rural populations. This study evaluates a community based health insurance contract by randomizing the insurance offer to women in microfinance Self Help Groups in rural India. There is no support for increased use of health care, instead, limited suggestive evidence of reduction in health shocks and health care utilization has found. There is also some suggestive evidence that the insurance offer reduces health expenditure and health related debt. This suggests scope for additional indirect benefits of increased health to insured members and assisting in the financial sustainability of CHBI contracts.

Similar to the microfinance revolution increasing access to credit, CBHI are arguably more successful at providing insurance by being better at overcoming the high loading costs and asymmetric information that prevent other insurance providers. Though community based health insurances differ in design subtleties, they also share a variety of common characteristics, such as lowering the price of health care, creating a network of facilities, and having a relatively low upper limit of coverage. CBHI differs from larger insurance companies in that they are often organized in closer connection to the local population, and in recent

years, many have attempted to reach remote poorer populations by building upon preexisting microfinance structures.

A primary purpose of most of these programs is to both lower health expenditures and improve health care access of those who become insured. However, the extent to which CBHIs successfully achieve these goals is critically dependent on how insured members change their demand for health care in response to the insurance contract. When faced with lower health care costs, the direction and amount of change for health care consumption is ambiguous. To the extent that the insurer cannot observe the required treatment for the illness and lowers the cost of care, the quantity of health care demanded will increase. Such an increase may be seen as desirable increased access to health care for a population typically seen as underserved, such as the rural poor in a country like India. In theory, an increase in health care demanded could even lead to an increase in out of pocket health care expenditure by members, though this would imply a price-elasticity beyond what is commonly empirically estimated. Members may even respond to being insured by increasing their health care consumption by such a large amount that the insurance contract becomes financially unsustainable and even unravels as the cost of insurance becomes higher and higher.

When reducing the price of health care, we often assume that the overall quantity of health care consumed will increase. A common concern of insurance is that because it effectively lowers the price of health care for the insured individuals consume more health care than if they were uninsured. In a developing country context such as India, this may be considered a positive effect by increasing access to healthcare. Nevertheless, because households also decide when and what type of health care to access, it may be the case that health improves and overall health care consumption decreases. The dynamics between these two factors, decreasing the costs of assessing health care and the timing and quality of the health care purchased, leads to a theoretically ambiguous response in the change of health care utilization when members become insured.

Consider a household that has the choice of seeking health care immediately or waiting to seek health care in the future depending on the course of the illness. If the household chooses to wait, with a certain probability they will recover on their own and will not have required any health cost. Alternatively, the illness may advance over time and require an increased amount of health care. Below I outline a simple two period model in which a household can either
1) Seek care immediately when illness is still uncertain and face lower health expenditure with certainty, or
2) Wait until the second period where the illness shock will become known, but conditional upon receiving a health shock the health expenditure will be higher.

We assume the household derives utility from two parameters, consumption and health. If the household chooses to purchase health care in period 1, then the household is not in risk of a health shock in period 2, and has the following expected utility (with certainty):

$$\textbf{1) } EU = (1+\beta)u(y-P*H_1, \bar{H}+H_1),$$
$$\text{s.t. } P*H_1 < Y$$

However, if the household chooses not to purchase health care in period 1, they risk a negative health shock in period 2 and have the following the expected utility:

$$\textbf{2) } EU=(1-\pi_s)\,(1+\beta)u(Y, \bar{H})+ \pi_s[u(Y, \bar{H})+\beta u(Y-P*H_2, \bar{H}-\theta+H_2)],$$
$$\text{s.t. } P*H_2 < Y$$

where π_s is the expected probability of the health shock in the second period, β is the discount rate for the second period, Y is the household's income endowment, $\bar{H}$ is the household's health endowment, P is the price of health care, and H is the amount of health care required to be purchased, assuming $H_1<H_2$.

Depending on which equation yields a higher expected utility, the household will either purchase or wait to purchase health care in the first period. Depending on the curvature of the utility and the above

parameters, such as the discount factor and the difference in health care required between the periods, one may choose to take the risk of increased health care in the future on the chance of not having to pay any health expenses. Assuming a homogenous society, if the expected utility of Eq (1) is higher, we would expect the population's average health care utilization to be H_1 , with an average cost of $P*H_1$. If expected utility of Eq (2) is higher, then average health care utilization would be π_s*H_2, with average costs being π_s*P*H_2. Which of these imply a higher health care utilization would depend on the parameters mentioned above. For example, as we imagine households to have higher and higher discount rates, they will be more likely to forego health care in the first period since the potential cost in the second period is valued less in the present period, even if poor health and health care utilization would be lower had they chosen to seek health care earlier.

A health insurance program effectively lowers the price of health care, P. While this is often done through directly lowering the monetary price of health care, it could also include other measures that lower the cost of seeking health care, such as creating a network of health facilities with increased quality or doctor visits which reduce the costs associated with travel. Using the model described above, a decrease in the price of health care could either cause people to seek care earlier (now that the foregone income is lower) or cause people to seek care later (now that the risk to income from waiting has also reduced). Depending on which effect dominates, we could see a rise or fall of health status and health care utilization.

In the above model we assumed a fixed requirement of health care. However, the amount of health care purchased is also a factor in the household's decision making process. Though the potential health burden increases in period 2 if health care if not sought earlier, the household still chooses how much health care to purchase in both periods (i.e., H_1 and H_2 are usually not fixed amounts as depicted in the model above). Thus for any of the given periods, assuming increasing returns to health care, a drop in the price will lead to an increase in the consumption of health care.

Thus, the combination of reducing the price of health care with the dynamic element of when and what type of health care to purchase leads to ambiguity when predicting how health care utilization will change under a health insurance program that lowers the cost of health care.

The success and effectiveness of insurance contracts are critically dependent on the health care utilization of its member base. An increase in health care consumption is often an indirect goal of community based insurance providers, though it also raises concerns of the financial stability of the insurance contract. Contrary to the majority of studies evaluating CBHI, this insurance contract does not increase health care consumption. Instead, limited suggestive evidence of the insurance possibly reducing the consumption and expenditure of health care. Not only is this indicative of improving the health status of the insured, but additionally helps households with their health expenditure beyond the discounted health care received directly through the insurance. Furthermore, a decrease in health care utilization increases the probability of financial sustainability of the program. However, the insurance lowering the need and demand for health care is only one possible interpretation of the findings, and thus should be considered an upper limit. In general, the potential of CBHI to increase health status and lower the amount of health care warrants further research. Numerous factors in the design of the CBHI may be responsible for decreasing the barriers of access to health care and potentially reduced health shocks: direct price reductions, network facilities with quality checks, and local doctors being monitored. Further research is required to decipher which of these factors led to a decrease in health shocks and health care utilization and how these can be promoted and integrated into the designs of CBHI programs.

*(The write up is an extract from the study report written by Ms Ketki Sheth with same title, shared with us by **Chaitanya**.)*

International Microfinance Research Workshop

On 15th-16th July, Sa-Dhan, Sahulat Microfinance Society, Banque Populaire Chair in Microfinance of the Burgundy School of Business, France and Fortune Institute of International Business (FIIB) jointly organized **1st Annual International Microfinance Research Workshop**. This year the theme was ***"Crowd, Cooperative and Harmonious Development"***. The workshop witnessed participation from government, academia, MFIs, technology service providers from various countries and so forth.

This annual workshop called the Participation for Harmonious Development (PHD), intends to bring together microfinance and every possible initiative being implemented anywhere in the world that would result in the creation of harmony among the participants.

In order to orient the international participants on microfinance operations in India, on first day Sa-Dhan organized one field visit to Satin Creditcare Network Ltd at Pilkhua a small town in Uttar Pradesh. The second day witnessed deliberations and paper presentations on various thematic and contemporary topics.

Major Policy Updates in Microfinance

Financial Inclusion and Development Department	
28 JUL	The limit of the loans extended by Non-Banking Financial Company- Micro Finance Institutions (NBFC-MFIs) for which the tenure of the loan shall not be less than 24 months, has been raised to Rs. 30,000/- from the earlier limit of Rs. 15,000/-.
07 JUL	RBI has released a Master Circular to enable banks to have current instructions at one place. Read more about the circular.
01 JUL	In order to enable the banks to have instructions at one place, a Master Circular incorporating the existing guidelines/instructions on SHG-Bank Linkage Programme has been updated.
Department of Non-Banking Regulation	
28 JUL	It has been decided to extend the guidelines, mutatis mutandis, to NBFCs, in areas affected by natural calamities as identified for implementation of suitable relief measures by the institutional framework viz., District Consultative Committee/ State Level Bankers' Committee. Read more.
23 JUN	To ensure consistency in the manner in which the information is received from the Auditors, it has been decided to introduce a uniform format of the SAC. Read more.
02 JUN	NBFCs may refinance any existing infrastructure and other project loans by way of take-out financing, without a pre-determined agreement with other lenders, and fix a longer repayment period, the same would not be considered as restructuring. Read more.
26 MAY	The Reserve Bank of India (the Bank), having considered it necessary in public interest and being satisfied that, for the purpose of enabling the Bank to regulate the credit system to the advantage of the country, it is necessary to amend the Systemically Important Non-Banking Financial (Non-Deposit Accepting or Holding) Companies Prudential Norms. Read more.
28 APR	In order to bring parity with risk weights assigned to investment in corporate bonds by SPDs and banks, it has been decided to link the risk weights, assigned by SPDs to their investments in corporate bonds. Read more.

Please share articles and write-ups on developments at your institutions to saibalpaul@sa-dhan.org and sree@sa-dhan.org