MicroSave India Focus Note 93

Health Emergencies: How Do The Poor Pay?

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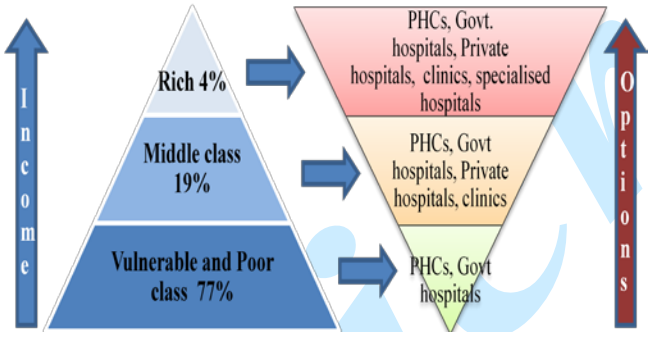
"Approximately less than one sixth of India's billion people have access to affordable healthcare. For the rest, medical help is often inaccessible and beyond their means. Too often, the cost of staying alive pushes one quarter of Indians below the poverty line and hospitalisation can result in years of debt repayment, so that rural indebtedness caused by illness is frequently far greater than that caused by crop failure".

- Case study on Yeshasvini Health Insurance Scheme, Public/Private Partnership – a Reformist Agenda in the Indian Health Sector, P.M. Mathew

Medical care is of utmost importance to everyone, irrespective of rich or poor. The rich have surplus cash at their disposal to pay for access to hospital networks, treatment, access to good doctors and timely medical advice. The poor cannot afford access these services, which results in further financial pressure on their households.



India's population by different expenditure class and the choice of health care available to them

Though, the accessibility of medical services to people is in direct proportion to their income levels, aspirations are often similar. Recent research by *MicroSave*, highlighted that even though expenditure at a private hospital is exorbitantly high, the poor always try to approach a private hospital to the best of their ability to pay. The India Health Report 2010 notes that many households in India spend 7% of total expenditure on healthcare.[1]

This Note describes the ways how low income families in India deal with their medical exigencies in the absence of quality public heath care facilities. These include:

Savings: The first source is household savings. *MicroSave* studies[2] in India show that almost all poor people save in some form or the other, but not specifically for medical contingencies. Some save for purposes like marriage and education, but this is diverted for medical expenditure in case of emergencies.

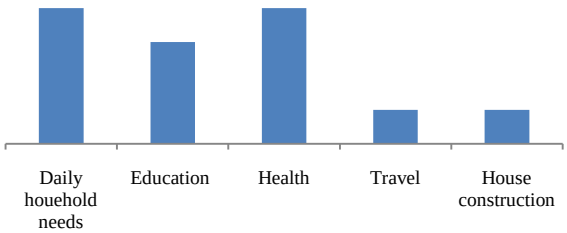
"We keep some amount of emergency funding with us. This is used if anyone in the family falls ill."

- A woman in the market research in Kerala.

Self Help Group (SHG) Loans / Emergency Loans: SHGs lend to members to help manage contingencies. However, members have to inform the group about a week in advance when they need a loan. Hence this source is less useful during medical emergencies. Also in some cases microfinance institution (MFI) loans are diverted for health purposes, or emergency loans are taken from those MFIs that offer these facilities.

Acquaintances: Those who do not have SHG/MFI membership and are facing an emergency, often borrow from their employers, neighbours and friends. For example, vegetable and fruit vendors borrow from the wholesalers and the loan is then adjusted through their subsequent weekly purchase of goods. However, since these lenders also belong to the same socio-economic stratum, they lend only for short durations. Most times, the amount lent is also insufficient to cover all health related costs. Also there is no guarantee of getting access to this type of loan, since it depends on factors like availability of cash on hand with the lender, the relationship between the lender with the borrower and, ultimately, the willingness to lend.

Major Household Expenses, *MicroSave* Research, Kerala



Bank Loan: Since many poor people simply do not have access to credit from banks, and taking a loan from banks is

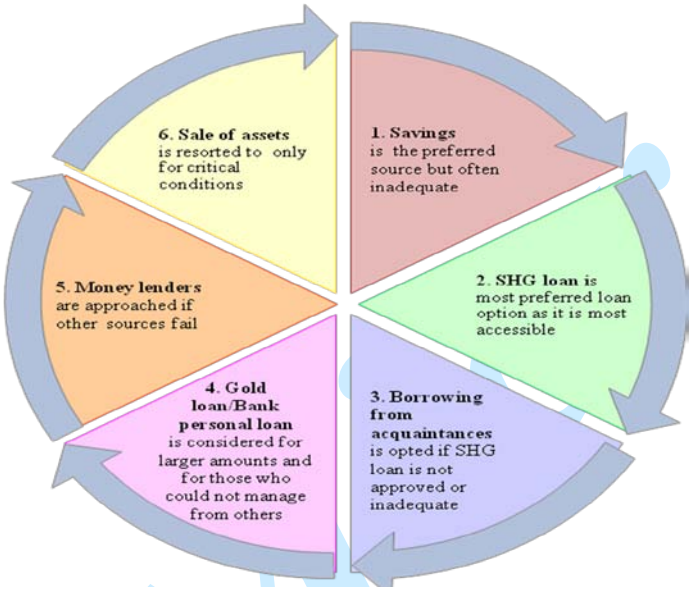
[1] http://www.medindia.net/news/Survey-Says-7-of-Total-Expenditure-Spent-on-Healthcare-by-Indian-Households-74115-1.htm

[2] See, for example, India Focus Note # 13, "Savings Behavior of the Poor people in the North East of India" and http://microsave.net/research_paper/relative-risk-to-the-savings-of-the-poor

difficult and time-consuming, the frequency of bank loans as a source to finance health costs is limited. This facility is used mainly by higher income people and those who have regular sources of income. Moreover, only planned health expenditure can be managed from the banks, since emergency loans are not available.

Moneylenders: Local moneylenders[3] lend at 3-10% per month for emergency loans. Many times, moneylenders take collateral for these loans. Since they live in neighbourhood and give instant loans, moneylenders are commonly accessed for emergency health needs, even in areas where SHGs or MFIs are abundant. They are popular, in spite the usurious rates they charge, simply because they are so convenient and quick to respond.

Pawning or Sale of Assets: When other sources are inadequate, the poor resort to pawning or selling jewellery, houses, agricultural land or other immovable property to raise money for emergencies. In case of pawning, if they repay, the pawned property is returned – otherwise it is forfeited.



Source of Capital, *MicroSave* research

The expenditure to meet a major health shock is likely to push a low income family into distress. Even if the money needed for treatment is arranged (through one or more of the sources above), the household is likely to face significant pressure on its finances subsequently.

> *"People who are salaried take loans from banks. Others like us borrow from relatives and friends. Else we take it from bishis (ROSCAs) and bachat gats (SHG). Finally, if nothing works out, we go to the government hospital."*
>
> \- A snack vendor in Pune slums

For example:

- To manage the initial health shock, the family may have dipped into the long-term savings for life cycle events like children's marriage or constructing a house. However, the pressure to recoup the eroded savings is likely to haunt the family as their dreams of buying a house or marrying her children are compromised.
- The person might have taken a costly loan to meet emergency health expenditures. There is pressure to repay loans from SHGs and friends/relatives as early as possible to maintain social esteem. Similarly, if the loan was from a moneylender, there is a danger of confiscation of the hypothecated assets (jewellery, land etc.).
- If the money were arranged through sale of income earning assets (e.g. agricultural land), there is a high risk of the family becoming trapped in a vicious circle of poverty.

Increased working hours, removal of children from schooling and curtailed basic living expenses are common results of medical emergency-induced distress in low income families.

Health Insurance As The New Paradigm

The methods elaborated above highlight the fact that medical emergencies create very difficult situations for the poor. Health insurance programmes like the government sponsored RSBY,[4] and Kalaignar Health Insurance Scheme or cooperative health insurance schemes like Yeshasvini, Uplift Health Mutual Fund and VimoSEWA are affordable alternatives for low income and poor families. Assessing the pros and cons of each of these schemes is outside the scope of this note, but these subsidised, gender-neutral programmes provide affordable healthcare to the poor families at low cost. (Example per year premiums: RSBY: Rs.30 per family; VimoSEWA: Rs.400 per family and Yeshavini: Rs.150 per person.) The benefits provided by them include claims reimbursement, free hospitalisation, free/low cost surgeries and network hospitals. However, the idea of health insurance or health financing is new to the low income population. Reasons like inappropriate products, lack of insurance awareness, limited trust in the insurance agents, previous experiences of fraud, or lack of trust in insurance companies[5] add to the poor penetration of such schemes.

Also most of the schemes mentioned above are facing challenges of sustainability because of which they are unable to provide holistic (primary - tertiary) health services to the poor. In most cases the health product has been a push product rather than a carefully designed one which suits the needs of the target (BoP segment) market. These challenges must be addressed in health microinsurance is to reach significant scale in India.

[3] http://microsave.org/research_paper/relative-risk-to-the-savings-of-the-poor
[4] Rashtriya Swasthya Bima Yojana
[5] *MicroSave* study on "Savings Bundled Insurance in Rajasthan and Bihar", August 2010