MILK Discussion Note #2: Are Existing Health Financing Mechanisms Sufficient for Poor Women in Guatemala? [1]

BanRural is a bank offering microcredit, savings, and remittance products to small and medium-sized enterprises and individuals in rural areas of Guatemala, as well as insurance products through its affiliate Aseguradora Rural. In 2010, through a grant from the ILO's Microinsurance Innovation Facility, BanRural began to explore the possibility of offering health microinsurance products to its existing clients, beginning with the 366,000 female small savings account holders with a "Senora Cuenta"[2] account. As a first step, a market study was conducted (see box) in order to develop a clear understanding of women's health risks, health usage and costs. The MILK Project has reviewed some of the data from the market study to develop a better understanding of the **health financing alternatives available to poor women in Guatemala** and develop a hypothesis of the value that microinsurance might have for poor women. This hypothesis will be tested once Aseguradora Rural launches a new product aimed at covering women's health needs and marketed to savings clients of BanRural in the last quarter of 2011. The MILK Project will then implement its Client Math methodology to study the direct value that the health microinsurance product has on poor women by comparing the financial costs of gynecological health for women with the product to those of women without the product. The Client Math study will also seek to understand the role of insurance in increasing access to health care for low income women.

The Market Study, Supported by the ILO's Microinsurance Innovation Facility

As part of a market study of BanRural's clients in two regions of Guatemala (Momostenango and Santa Rosa), Aseguradora Rural offered two-day free medical clinics at the two bank branches. This had the dual objective of attracting clients and collecting both clinical and extensive survey data while clients waited for free checkups and diagnostic screenings.

The resulting surveys of 268 women provide both clinical data and information about where, how, and when these women pay for health care. The study concluded that there was strong demand and need for low-cost women's health insurance coverage. Respondents were also deeply concerned for their children's health, but had more options to finance this care through free public centers and/or from household income. The study was conducted by EA Consultants.

The context: Poor, vulnerable population with limited access to public safety nets

Guatemala is one of the poorest countries in Latin America, with a GDP per capita of USD 2,661[3] per annum in 2009, roughly one-half that of the average for Latin America and the Caribbean (CIA). The distribution of income is highly unequal, with the richest 10% of the population accounting for more than 40% of Guatemala's overall consumption. More than half of the population is below the national poverty line and 15% lives in extreme poverty. Rural women are among the most vulnerable groups; they are much less likely to be employed than people in urban areas or men in rural areas,[4] and even when they are employed, average salaries are only 83% of men's salaries.[5]

Guatemala's public health expenditure is among the lowest in the Americas (around 1% of GDP). Twenty

[1] This brief offers a summary of the findings of a joint study by the MILK Project and the International Labour Organization's Microinsurance Innovation Facility of clients of BanRural in Guatemala. It was authored by Barbara Magnoni, Derek Poulton, and Emily Zimmerman.

[2] "Mrs. Account"

[3] http://data.worldbank.org/indicator/NY.GDP.PCAP.CD

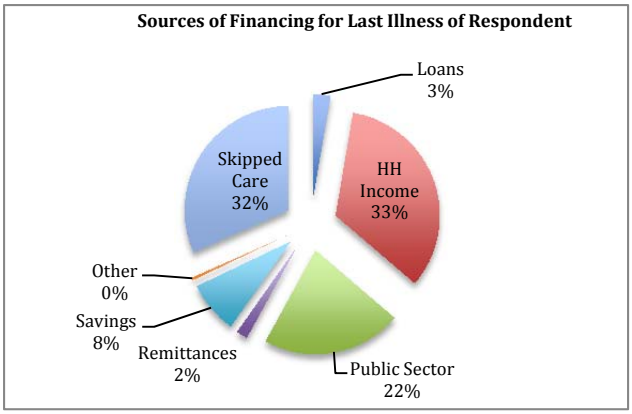
[4] Women make up 30% of the economically active population in rural areas. National Statistics on Gender and Health Expenditures, INE 2004

[5] Charts for Publication doc – natl stats gender and health exp tab. Cited as "INE 2004"

percent of its population lacks regular access to health services, and the quality and effectiveness of public services are limited.[6] As a result, poor women, in particular those residing in semi-urban and rural areas, face limited choices for health care. Formal sector workers, who represent 25% of the population, have access to social security health care through public and private clinic networks. The remainder of the population, including the majority of BanRural's clients, turns to free public clinics, skip care, or, when they can, use private health service providers. There is a strong preference among the respondents in the study for **avoiding care from the public sector**. Previous studies have shown that Guatemalans avoid public sector healthcare for a variety of reasons, including remoteness or inaccessibility of facilities, lack of medicine at facilities (which means that patients have to fill their prescriptions at pharmacies), the practice of offering different services in public clinics at different times, poor interaction between patients and health care personnel, and discrimination due to the patients' indigenous ethnicity or inability to speak Spanish (COWI Consultants/World Bank, 2001; Gragnolati & Marini, 2003). High out of pocket health care spending reflects this at USD 186 per annum[7], or 7.1% of GDP per capita in 2009.[8]

The challenge of health care finance

A cash flow story. The study suggests that health insurance might have a useful impact on reducing cash flow pressure from spending on their own health care and that existing financial services may not be a good fit for these needs. The most common way of paying for health costs related to their own illness (33% of respondents) was through household income (18% used their own and an additional 15% used income from other family members to cover costs). Those who could not pay either skipped care (32%) or went to the free public sector facilities (22%). When asked about which types of recent illnesses respondents had suffered, they reported mostly common illnesses, and to a lesser extent chronic and critical illnesses. Interestingly, there is little variation in how women finance varying levels of severity of illnesses. Women with chronic or critical illness were just as likely to forgo care as women with common illnesses. They were less able to pay for care out of household income, however, and only slightly more likely to borrow money from a money lender to finance care when they did go. A small percentage reported using financial services (savings, loans, remittances and other) to cover these costs.



Does access to other financial tools help cover health care spending? When we analyze only those respondents who had loans with the Bank, 47% covered spending through household income: 34% used their own income and 13% used income from other family members. This highlights that these borrowers are much less vulnerable than non-borrowers, probably because they have higher incomes required for loan eligibility. While this group also used loans to pay for health expenses more frequently than those who were not borrowers with the Bank, it was not a common response. Only 4.2% of borrowers used bank loans while 3% used loans from loan sharks, primarily for critical and chronic disease care. This compares to 0.9% and 0,6% respectively for those who did not borrow with the Bank as well as an additional 1.2% that borrowed from friends and family.

Likewise, while savers and remittance recipients were more likely than others to finance healthcare through savings and remittances, respectively, those tools still made up a relatively small proportion of financing tools. Although a large number (63%) of survey respondents had savings accounts, few respondents reported financing health care expenses with their savings. Only 10% of respondents with savings accounts used savings to pay for common illnesses, while 6% and 8% used savings to pay for

[6] World Health Organization, Country Cooperation Strategy At-A-Glance. May 2007.
[7] http://data.worldbank.org/indicator/SH.XPD.PCAP
[8] http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS

critical or chronic illnesses respectively. In focus group discussions, respondents noted that savings were "earmarked" for their children's expenses (school, health, emergencies) or household aspirations (home improvements or additions). These women were resistant to tapping into these funds for their own healthcare. This finding is especially pertinent in that it adds a new dimension to the existing knowledge of savings as a coping strategy for risks for the poor. The literature often suggests that savings can be effective tools in coping with risks, including health risks, although they are often inadequate to cover the full costs of large shocks (Dercon, 2000; Kendall, 2010; Morduch, 1995), however, this sample of respondents are not paying for health shocks with savings for the most part.

A relationship between financial costs and stress: A key finding from the market study was that there is a strong relationship between health care spending[9] and stress conditions among respondents. Existing literature points to evidence that the financial strain of health financing can increase the stress women experience, with potential physical and psychological consequences. A study of predominately Hispanic low-income women in the US showed that economic stress of cancer patients (indicated by employment status, medical cost concerns, and worries about wages lost due to illness) was associated with significantly poorer functional and emotional well-being and significantly higher incidence of anxiety and depression (Ell et al, 2007). In the Guatemala survey, "stressed" women (measured through self reported claims of stress, anxiety, and other psychological disorders) spent around GTQ 558 (USD 70) more per year on health and approximately GTQ 93 (USD 11.6) more per visit than "unstressed" women.

Does health care finance matter?

The findings suggest that health financing does matter, and that existing financial products and services available to the respondents such as loans, savings and remittance receipts are insufficient to meet these needs. Additionally, the findings suggest that the costs of financing health care are closely tied to anxiety and stress. There has been some initial evidence (Clarke and Dercon, 2009; Collins, Morduch, Rutherford, and Ruthven, 2009; Gertler and Gruber, 2002)[10] of the financial benefits of microinsurance in poor households. However, little of this evidence looks specifically at the extent to which health insurance offers value through cash flow smoothing when poor households face **small** shocks. This evidence from Guatemala, however, suggests that cash flow effects can be important, as more frequent illnesses are typically paid out of an individual's or household's income.

Aseguradora Rural has developed a women's health insurance product based on the market study, which showed, among other diagnoses, a high incidence of high frequency and low risk gynecological infections as well as concerns expressed by women of cancer and its devastating financial and emotional effects. The product covers preventative and curative gynecological services for low-income women as well as cancer indemnity coverage. This represents a first step to reducing health expenses by combining preventative care with insurance coverage of less frequent costly illness. The MILK project's hypothesis is that this low cost microinsurance product will smooth cash flow pressure from preventative and early stage care. It may also improve access to care as well as relieve some pressure on women's spending on health care for common outpatient care, diagnostics and early stage treatment of pre-cancerous lesions. The MILK Project plans to implement a Client Math study once the product is launched to better understand the value the product offers women clients in reducing their out of pocket expenses and improving access to care.

Microinsurance Learning and Knowledge (MILK) is a project of the MicroInsurance Centre that is working collaboratively to understand client value and business case in microinsurance. Barbara Magnoni leads the client value effort and Rick Koven leads the effort on the business case. Contact Michael J. McCord (mjmccord@microinsurancecentre.org), who directs the project, for more information.

[9] Only in the case of their own health, not in spending for their children's health care.
[10] See MILK Brief #4: What We Know About the Financial Value of Microinsurance for Poor Clients: A Snapshot

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