Microfinance, Gender and Rural Health Care in Bangladesh

Syed M. Ahsan

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Abstract

Some key results arising out of the research underway at the Institute of Microfinance (InM) relate to the nexus between health, gender and microfinance. First note that the 2009 survey yielded information on 19,424 (48% female) individuals belonging to 3,941 households (HHS). By research design, Grameen Bank (GB) is a dominant player in the program zone such that of the 3,941 households (hhs), 1,291 (ie, 33%) were GB members, 847 (about 21%) other MFI borrowers, while 1,803 (46%) were not members of any microcredit program. Further, among the 3,941 households, 2,477 were located in the catchment area of selected Grameen Kalyan (GrK) health centres, with 935 hhs being cardholders (CH) of health intervention while the remainder 1,542 as non-cardholders (NCH). The adjacent control areas contained 1,464 hhs.

For example, on gender, it is seen that (i) women have a significantly higher rate of morbidity than men, though (ii) neither the gender of the patient nor the gender of the household head mattered in the choice to seek a formal provider (as opposed to informal). Even then, (iii) illnesses experienced by female members lead to lower total out-of-pocket payments (OOPP) than for males. It is further seen that (iv) in financing OOP costs incurred on behalf of female patients, less use is made of burdensome means of coping (namely, additional borrowing and asset sales) vis-à-vis males. Instead households rely more on current income and utilize available saving for this purpose.

The scope of microfinance and NGO health intervention also appear new to the literature. Estimates from the random intercept logistic model support the hypothesis that (1) enrolment in GrK micro health insurance scheme has had a significant impact on the likelihood of the utilizing formal care, while (2) microfinance borrower status alone (i.e., without the 'health insurance') is actually negatively associated with the likelihood of accessing formal care. It is further seen that (3) while GrK cardholders make greater use of formal care (i.e., in the nature of discounted serves as CH beneficiaries), they incur lower OOPP in the process. Curiously, however, other microcredit recipients (but without CH), who seek formal care less often, that too leads to lower OOPP, *though the quality of care may differ between the two modes*.

Interestingly, (4) while tending to lower the level of OOPP, microfinance with or without health innovations, fail to impact upon the incidence of catastrophic expenses (CHE), namely events where OOPP exceed 10% of annual hh expenses among their members. In other words, neither the GrK health intervention nor the liquidity facilitated by MFI credit flows to the household is

adequate to meet the catastrophic expenses, which essentially requires further means of finance. Intriguingly it is seen that (5) while all borrowers and GrK CHs (regardless of their borrowing status) generally incur additional borrowing to finance OOPP, the reliance on asset depletion is significantly lower for GB borrowers.

There appear few studies that have data of sufficient depth to reflect on these nuances of microfinance delivery. These findings appear worthy of further analysis in the context of wider datasets, not necessarily focussed on GB.