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doi:10.1016/j.worlddev.2009.10.019

# Do Spouses Make Claims? Empowerment and Microfinance in India

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**Summary.** — We study a microfinance program that provides compulsory health insurance to its borrowers and their spouses. We find that non-borrowing spouses are less likely to file insurance claims than those who are borrowing. Further, a man is more likely to use the health insurance acquired through his wife's loan than is a woman (through her husband's loan). These patterns suggest that women who do not borrow are disempowered relative to those who do.

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*Key words* — health insurance, microfinance, claims, gender, empowerment, India

## 1. INTRODUCTION

Many households in developing countries are especially vulnerable to health risks. For instance, Peters *et al.* (2002) estimate that a quarter of all Indians that are hospitalized fall below the poverty line as a consequence. In such a situation, the provision of health insurance has huge potential—but also faces at least two constraints. First, the transactions costs of such micro-insurance can be particularly high (Morduch, 2007). Second, women may not utilize health insurance even if they are sick. There is considerable evidence that men and women differ in their *health-seeking* behavior, that is, in how they perceive their symptoms and translate that perception into treatment based on the social and cultural context (Santow, 1995).

One promising approach to deliver health insurance to the poor is in partnership with microfinance institutions. Such programs can save on transactions costs by using their existing rural networks. Further, since a goal of microfinance is to empower women, we might expect that microfinance can reduce the gender disparity in health seeking. Many prominent microfinance institutions in South Asia offer health insurance schemes in conjunction with their loans (Roth, Churchill, & Namerta, 2005). This recent and potentially important development in micro-insurance has been little studied.<sup>1</sup>

In this paper we study an innovative microfinance institution in India that requires borrowers and their spouses to purchase health insurance when the loan is given. We analyze the claims behavior of borrowers and their spouses, of men, and of women. Our goal is to understand how microfinance, gender, and health insurance interact. The key feature of the program is its group health insurance coverage. Borrowers and their spouses receive the same coverage and pay the same premium regardless of their sex, age, or any medical histories. In other words, the health insurance intervention treats everybody the same—so any differences in claim behavior must be related either to differences in underlying morbidity or to differences in health-seeking behavior.

We find that there is a *borrower-spouse gap* in health insurance utilization—borrowers are twice as likely to file claims as

their spouses. We also find a smaller husband-wife gap in health utilization, that is, wives of male borrowers are significantly less likely to file claims than husbands of female borrowers. This borrower-spouse gap and the husband-wife gap persist when we control for gender, age, length of coverage, previous claims, and previous experience and unobserved branch-level differences. While we cannot rule out morbidity explanations for our findings with the available data (i.e., that borrowers are more sickly than spouses, and wives are more sickly than husbands), these results are also suggestive of health-seeking differences.

Gender differences in health are related to women's empowerment within the household in India (Basu, 1992; Bloom, Wypij, & Dasgupta 2001). Women, particularly younger women often do not have much say in their own health decisions in India. Instead, husbands and even mother-in-laws make health care decisions for them. Our results suggest that non-borrowing female spouses are disempowered within the household. Put differently, women who borrow are empowered in their health seeking compared with women who have acquired health insurance through their husbands. These findings are consistent with both selection and/or treatment effects of microfinance on female empowerment. Microfinance institutions may be selecting empowered women as borrowers—and/or they may be making their female borrowers more empowered relative to female non-borrowing spouses. We cannot distinguish between these two possibilities.

Our paper contributes to a literature on female empowerment and microfinance (Anderson & Baland, 2002; Mayoux,

\* We are grateful to the microfinance institution in India who shared their internal data and time with us; to participants at the 2007 Groningen Microfinance Conference, Population Council, Ford Foundation and to two anonymous referees, Sajeda Amin, Mudit Kapoor, Stefan Klöner, Craig McIntosh, Jonathan Morduch, Peter Nurnberg, Anand Swamy and Vijay Mahajan for useful comments and discussions. We thank Karuna Krishnaswamy and Martin Rotemberg for excellent research assistance. Any remaining errors are our own responsibility. Final revision accepted: October 30, 2009.

1999, 2001). Female empowerment has been defined and measured in multiple ways in the microfinance literature. Measures include physical mobility of women (Hashemi, Schuler, & Riley, 1996), control over the use of the loan (Goetz & Sen Gupta, 1994), intra-household decision making (Holvoet, 2005), domestic violence (Kim *et al.*, 2007) and contraceptive use (Steele, Amin, & Naved, 2001). We do not measure empowerment directly; instead we use health insurance utilization as an indicator of empowerment. While much of the research on the subject is on the well-known Bangladeshi microfinance programs that typically exclude men, our study looks at a program that includes both men and women. Approximately half the borrowers are male, and half are female. This allows us to contrast the health seeking behavior of men and women borrowers with their male and female spouses. When loans are targeted to women, such a rich comparison is not possible.

The outline of the paper is the following: Institutional details, selection issues, description of the data and empirical analysis are in Section 2. Section 3 has discussion of the results where we distinguish between morbidity and health seeking hypotheses. We conclude in Section 4.

## 2. CONTEXT

### (a) *Institutional background*

The Indian government has taken a proactive role in extending microinsurance to under-served areas. Since 2002, the government has required private insurance firms to sell a fraction of their insurance policies in rural areas and imposed fines if the firms did not comply. Consequently several private insurance firms have set up partnerships with microfinance institutions (MFIs) to meet the government imposed quotas (Roth *et al.*, 2005). In these arrangements, the insurance firm subcontracts the selling of insurance and the processing of claims to the MFI. The insurance firm bears the risk and the MFI takes on the administrative costs of delivering insurance in rural areas.

In this paper we use data from an MFI in India that has partnered with an insurance firm to provide health insurance across 14 states in India. The data includes basic information on all individuals covered by health insurance and some details about the nature of claims. The health insurance program was started in May 2005. All borrowers between the ages of 18 and 55 who took loans after May 1, 2005 were required to pay a health insurance premium in exchange for modest hospitalization expenses. A year later, starting May 1, 2006 insurance coverage was also required for spouses of borrowers (provided they met the age requirements). The premium for each individual was Rs. 76 (US \$1.7). The maximum benefit levels were fixed: Rs 1,500 for up to 5 days spent at the hospital, Rs. 10,000 for critical illness, and Rs. 25,000 for permanent accident (the exchange rate was 45 rupees per dollar). The annual premium was fixed regardless of borrower age, sex, or health history (since the insurance was offered as a group plan).

The MFI prohibits a household from taking multiple loans—so a husband or his wife may take a loan, but not both. Note that borrower households are required to purchase health insurance (provided they are age eligible). This insurance program is not open to non-borrower households.

### (b) *Selection issues*

In order to understand the selection issues involved here, it is useful to compare the actual program with a hypothetical

randomized experiment. Suppose that loans are given to a spouse in a household (chosen at random) and health insurance is required of both spouses in the household. In such a situation, there should be no differences in the probability of filing claims for borrowers and their spouses.

In our study there is non-random intra-household selection into loans—and this selection may in turn depend on the health insurance coverage associated with the loans.<sup>2</sup>

Within households, there is deliberate selection as to whether the husband or wife takes a loan since both cannot borrow. Further, before May 2006, this selection may indeed be prompted not just by the loans but by the health insurance coverage associated with the loans. So for instance, we might expect sicker spouses to decide to become borrowers precisely because they have a higher value of health insurance. Since both the borrower and the non-borrowing spouse are equally covered by health insurance after May 2006, however, there should be no intra-household selection into loans based on the health insurance offered. For this reason, we restrict our sample to those borrowers and their spouses who have obtained health insurance coverage after May 2006.

### (c) *Sample of borrowers and spouses*

We restrict attention to borrowers and their spouses who received insurance starting on May 1, 2006 or later (for the reasons explained above). Our sample consists of 802,998 individuals whose health insurance coverage started on or after May 1, 2006. Of these, half are male and half are female. Approximately 55% are borrowers and the rest are spouses of borrowers. The average age is 34.16 years (Table 1).

The average loan size is Rs. 11,077 (US \$246) and is paid in 14.4 installments (Table 1). The reported activities for which loans are taken are in Table 2. Dairy and shop keeping are the two most prevalent uses for loans (though there is also a substantial uncategorized component). Only 9.3% of the loans are taken for cultivation. This is compatible with microfinance programs worldwide which primarily give loans for microenterprises other than cultivation.

The sample includes individuals who are joiners, renewers, and leavers. Joiners are first-time borrowers and their spouses. Renewers are returning borrowers and their spouses. Leavers are those who repay their loans but do not immediately take another—and hence their insurance coverage lapses. Twelve percent of the individuals in the sample are joiners and 81% are renewers.

The length of coverage is calculated as the number of days between the start date of coverage and the end date or December 31, 2008 which ever came first. For instance, if a borrower took a 10 month loan on June 1, 2007, then his coverage would end in on March 31, 2007. If that loan was renewed for another 10 months, then the coverage period would be 20 months. The average length of coverage is 514 days.

Figures 1a, 1b and 1c compare age distributions for borrowers and spouses who were eligible for health insurance. Even though male and female borrowers have similar age distributions, male spouses are significantly older than female spouses. This reflects a common marriage practice in India and elsewhere: it is socially desirable for husbands to be older than wives. We test this formally using the Kolmogorov Smirnov test for the equality of distributions. We cannot reject the null hypothesis that the age distributions for male and female borrowers are equal. But we do reject the null hypothesis for the equality of age distributions of non-borrowing male and female spouses. Male spouses of borrowers are significantly older than female spouses of borrowers. We also compare

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