EUROPEAN
MICROFINANCE
AWARD 2021

Inclusive Finance & Health Care

- CONCEPT NOTE -

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EUROPEAN MICROFINANCE AWARD 2021

The European Microfinance Award 2021 on 'Inclusive Finance and Health Care' highlights initiatives that facilitate access to quality and affordable health care for low-income communities.

This Concept Note provides information on the topic of the Award. For instructions on how to apply, please refer to the Application Guidelines available on the Award website.

ABOUT THE AWARD

The European Microfinance Award is a prestigious annual award with €100,000 for the winner and €10,000 for the runners-up, which attracts applications from organisations active in financial services around the world that are innovating in a particular area of financial inclusion. It serves two parallel goals: rewarding excellence, and collecting and disseminating through multiple channels the most relevant practices for replication by others.

The Award was launched in 2005 by the Luxembourg Ministry of Foreign and European Affairs – Directorate for Development Cooperation and Humanitarian Affairs. It is jointly organised by the Ministry, the European Microfinance Platform (e-MFP), and the Inclusive Finance Network Luxembourg (InFiNe.lu), in cooperation with the European Investment Bank (EIB).

The Award is presented in a ceremony which in the past has been in the presence of Her Royal Highness the Grand Duchess of Luxembourg and the Luxembourg Minister for Development Cooperation and Humanitarian Affairs. The ceremony takes place during European Microfinance Week.

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The Health and Poverty Trap

It is no exaggeration to say that health is the single most important thing in life. But beyond being sick or well, health underpins everything else: it allows education to play its role in opening new opportunities; it allows people to earn, invest and employ others; it lets groups and societies prosper. And the opposite is true. Without health - without health *care* to stop minor health issues becoming serious and to help people recover from serious health shocks - then all other metrics of progress are constrained.

The importance of health in human development is well established and at the forefront of international development efforts. Article 25 of the Universal Declaration of Human Rights states that access to health care is a fundamental human need. The Sustainable Development Goals (SDGs) link health outcomes to risk protection of poor households[1], and are accompanied by a wide range of indicators to monitor progress in reducing the impact of catastrophic health on low income people by country. The SDGs are supported by many other global initiatives, including the WHO's Triple Billion targets that set the goal of enabling 1 billion more people to gain health care access without financial hardship. And health drives development as much as development drives health; the Universal Health Coverage Coalition's states that 'Health is essential to eradicating extreme poverty and promoting growth of well-being. Over the decade to 2015, health improvements - measured by the value of life-years gained[2] - constituted 24% of full income growth in low and middle income countries.'

What distinguishes the health needs of the poor in low-income countries is the consequences of low-quality or unavailable health *care*. The global poor - the financially excluded - typically have volatile and precarious incomes and live in countries without high-quality universal health care. They not only need access to health care, but also the ability to pay for it.

Paying for health care is the single biggest financial risk facing poor households in low- and middle-income countries. The problem is two-fold: first, accessing and affording even basic or day-to-day health care (check-ups, medications or minor treatments) may be insurmountable for poor households. But second, even for those who are successfully

[1] SDG 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.
[2] The intrinsic value of additional life-years can be inferred from people's willingness to trade off income, pleasure, or convenience for an increase in their life expectancy (Global health 2035: a world converging within a generation; The Lancet 2013).

treated and fully recover from an illness or injury, the financial burden of the health shock can cast a shadow for years after.

The WHO estimates that about 150 million people worldwide suffer severe financial hardship each year from out-of-pocket expenditure on health services and 100 million are pushed into poverty as a result. The challenge has grown considerably in the last year, and the consequences of the pandemic on the world's most vulnerable may take years or decades to undo.

Financing health expenditures is one of the main reasons clients borrow from microfinance institutions (even if the ostensible reason is something else) and health issues - not just the direct costs but the opportunity costs of not working - are a driver of repayment issues as well.

The problem is fundamentally a human one. When facing the emotional stress of a health emergency, family members often seek out any options, no matter how costly, to access treatment. For poor households in countries without universal health care, this can mean taking on debt, selling income-generating assets or even their own homes. For families where the health shock prevents an income earner from working, the loss of assets to pay for treatment is magnified by the loss of income[3]. This risks a **negative feedback loop: poverty leads to bad health which feeds back to poverty.**

The Health Needs of Low-Income Communities

To break this negative feedback loop, low-income populations need: a) access to **day-to-day 'maintenance' health care** and the means to pay for it; b) to be protected from the devastating financial consequences of **sudden high-cost health emergencies**; and c) the means to deal with **all the circumstances in between**.

Fundamentally, healthcare needs follow a continuum[4], which can be subdivided into four segments based on their health situation and financial pressures. At one end is **regular and preventative maintenance**: the small but regular expenditures for vaccines against

[3] Collins et. al., Portfolios of the Poor, Princeton University Press, 2009. p.86
[4] This can also be considered as primary, secondary and tertiary care. Primary care is the broadest and first level of intervention when a patient sees a trained medical health provider, for advice, pharmaceuticals or physical treatment. Secondary care is acute care for a brief but possibly serious illness. Tertiary care refers to is specialised inpatient treatment for serious illnesses or accidents.

common diseases, dentistry and optometry, insecticide-treated nets (ITNs) to guard against malaria, and other miscellaneous hygiene needs - fresh water, sewage and clean air. Some are very cheap (ITNs), while others may be more costly (installing plumbing), but the majority are typically affordable to most households. Moreover, vaccines against frequent diseases such as measles and polio may be affordable but in some areas access may be limited. These preventative needs can often be met with existing savings, small and short-term credit and non-financial health care services where relevant such as educational camps or campaigns.

Level two are the majority of **health impairments**: influenza, minor wounds, snake bites, many digestive disorders and even recurrent bouts of malaria in some parts of the world. Most of these require some level of care (and in some cases the care is urgent), but the cost is typically modest and affordable to most people. Pharmaceuticals and outpatient consultations make up the bulk of most people's health care expenses. However, the challenge for these is that, even when predictable they're still unplanned and the specific financial needs aren't known ahead of time. The result for cash-strapped households is that such needs often coincide with a lack of liquidity: many households don't have the required funds at hand on short notice. Most level two needs can be met by savings and short-term credit.

Level three are serious **chronic diseases**: diabetes and heart disease, certain types of disabilities, being HIV positive, and other long-term conditions. Most of these can be managed for years with modest costs, but they require continuous expenditures via inpatient care as well as outpatient support and pharmaceutical support. Indeed, in some cases interrupting treatments can undermine the effectiveness of future treatments. However, they affect only a segment of the population, and often only at specific periods during their life. In many respects, these level three needs pose the biggest challenge for low-income households. For some of these, a combination of health insurance, savings and credit may meet the need. But other chronic conditions requiring expensive drugs cannot be sustainably met without outside support.

Finally, at level four are **serious and often sudden episodes of ill health** such as renal failures, severe accidents and burns, and cancer or cardiovascular diseases. These cases requiring costly in-patient care typically impose the biggest and most sudden financial costs, with potentially catastrophic effects on low-income households. Maternal health care which sits in level two when a birth is straightforward, can quickly escalate into level four when complications arise. Many individuals will never or only occasionally experience such level four episodes. Their low frequency and suddenness make it all but impossible to plan for, and their high treatment cost is too much for everyone except the wealthiest households.

Figure 1: Continuum of Health Care Needs

	Level 1: Preventative & maintenance care	Level 2: Minor health needs	Level 3: Serious chronic conditions	Level 4: Severe health episodes
Examples	Vaccinations Dentistry Optometry Bednets Good hygiene	Non-complication pregnancy Minor illnesses/ accidents	HIV Diabetes Organ disease	Heart attack Major trauma Cancer Complication pregnancy
Financial and non-financial Products	Ready cash Short-term savings Health camps Telemedicine	Savings Short-term credit Telemedicine	Savings, credit and insurance Subsidy/state support	Insurance

Everyone in the world has both generalised and individual health care needs. Beyond the needs that are applicable for everyone (dentistry, optometry and immunisation, for example) and the unique needs a person may have because of a particular condition, there are also needs associated with certain groups, based on age, gender, disability or genetic predisposition to certain diseases. Children obviously have specific health care requirements. The same is true for the elderly, those in ultra-poor or marginalised communities and ethnic groups with predisposition to certain illnesses. And women often have a dual role as child bearer - with all the antenatal and postnatal care that involves - and as primary household caregiver as well. All of these groups face barriers to access in addition to those faced by the financially excluded in general.

Some **barriers to access** are specific to their particular circumstances and needs, and some are exacerbated by a combination of low income and financial exclusion. They may miss out on preventative care because of the costs of taking time away from work. Volatile incomes may mean delays in treatment of fairly minor illnesses, turning treatable conditions into major or chronic problems. Rural and remote communities may not have certain medical services available at all. And the poor and vulnerable are often intimidated by health care professionals, and may be reluctant to seek advice, or even embarrassed to reveal poor literacy or numeracy.

The Barriers Facing Women

Women face particular barriers in accessing and affording adequate health care, a consequence not only of some cultural norms that restrict their financial autonomy but also women's typical role as primary household care-giver. Women's unique and additional health care needs is as true in high income countries as in low-income parts of the world. Moreover, the Covid-19 pandemic has already had particular negative consequences on women. According to UNFPA, even by April 2020, 47 million women had lost access to family planning and in the first six months of the pandemic, there were seven million unwanted pregnancies in 114 low and middle-income countries. And this is just in the initial months - and only in the area of family planning. More recent research continues to show the outsized effect of the pandemic on women. What the unique health needs of women means in practice is that gender dimensions need particularly careful attention when designing products and solutions in health care. As the ILO has put it: "The relationship between women, family health and barriers to financial inclusion need to be carefully understood before products and solutions are designed".

Financial Inclusion and Facilitating Access to Health Care

The financial inclusion sector can play an indispensable role in both helping households plan day-to-day medical spending and 'smoothing' out health-related financial shocks. By encouraging savings, designing appropriate credit and perhaps most of all, facilitating access to insurance, financial services providers (FSPs) can direct their core service expertise towards financial products that give low-income clients the financial flexibility required to meet their health care expenses. Beyond this, FSPs have strong and frequently high-touch relationships with a client base, often mostly women and sometimes linked together via group models with high social cohesion, creating an invaluable opportunity to advise on good health practices and educate on prevention and treatment.

Inclusive health care financing solutions are primarily *ex ante* arrangements set up to provide medically necessary care or the money to pay for it when needed. They may also include

additional features aimed at ensuring the quality and cost-effectiveness of care, to bring about behaviour change or support grassroots health care workers. Often, low-income households finance their sudden needs for health care by appealing to the solidarity of family and friends, liquidating formal and informal savings, taking up formal or informal loans or selling assets. However, FSPs can also offer health-specific financial products that go beyond generic savings accounts or microloans.

Yet health is a broad and complex sector. Very few if any financial institutions have either the capacity or the regulatory rights to provide health care directly. And the specialisation needed for health care delivery means that many programmes are designed to operate in **partnership** with a broad spectrum of stakeholders in the health care sector. FSPs, including insurers, may often enter into agreements with local clinics, pharmacies, NGOs or hospitals that may feature price discounts that can be passed on to clients or enable the FSPs to provide a variety of non-financial and educational health services.

The Limits of the Financial Sector and the Role of the State

No financial sector, no matter how motivated, can sustainably respond to all the health care needs of the country's population. Even in low-income countries with a small tax base, governments play a crucial role in ensuring access to quality health care for all. Besides providing infrastructure, training, regulation and standard-setting (among others), the State may also play a role through partnerships, especially by integrating existing community-based schemes into the government-run national scheme, or with the private insurance industry. In some cases, national social security health schemes themselves partner with insurers, NGOs and/or financial institutions to increase outreach to the informal sector that they otherwise have difficulty reaching through conventional channels, which are often designed with formal employment relationships in mind. In addition to providing the framework and rules under which insurance providers can participate in the partnership (e.g. cover levels, implementation details, etc.), governments can use these schemes to subsidise premiums to low-income or marginalised communities.

Financial Products for Health Care

Health Insurance

Insurance pools risks and transfers money to those who need it *at a particular time* from those who do not. It can cover both frequent and modest expenses as well as infrequent severe ones, and that range of coverage determines the price and affordability of a policy. But coverage even for very severe events is rarely unlimited, and small costs are likewise left to the client because insurance becomes administratively unsustainable for small, frequent expenditures.

Insurance is about the 'law of large numbers', which is why client-facing FSPs typically partner with insurance companies that can spread the risk across large groups of clients. The payment models of health insurance vary substantially, and can include **cashless** services, whereby the insurer rather than the patient pays the health provider directly; **managed care** models, where providers receive a fixed annual amount for everyone insured, in exchange for providing care for members of the insured group; **indemnity insurance**, which reimburses for different amounts of incurred expenses such as hospital bills; or the simple model of **sum insurance**, attractive to the provider, which provides a fixed amount of money when the insured event happens (for example, a fixed amount paid for every night spent in hospital).

From the client's perspective, an insurance premium is paid in advance, so, like saving, it functions as a **commitment device**. However, customers in emerging markets, who are often new to insurance, often struggle to understand the difference between insurance and savings, and expect their premium back if they do not use the insurance. Addressing these asymmetric expectations is a major challenge for insurance providers, and can be mitigated through communication and add-on features (such as vouchers for regular care) that increase the likelihood that the insured will use and value their insurance during the coverage period.

Savings

One of the most common reasons to save is for the proverbial 'rainy day'. But the 'rain' most commonly appears in the form of unexpected health care costs. When such needs arise, liquid cash is needed and savings are one of the least costly means to ensure the necessary sum. Unlike insurance premiums, the money in the savings account belongs to the saver and can be carried over from one year to the next, potentially incentivising health-promoting behaviour.

Any type of savings can be used to meet health care expenses, but a medical savings account that blocks the account from being used for non-medical expenses increases the chance that the funds will be there when needed. However, such accounts are typically limited to modest sums that might only cover regular health expenses. One exception to that is health care needs (for example, childbirth) that are both known and far enough in the future that a savings vehicle - particularly commitment savings - is almost perfectly suited for the purpose.

Credit

Medical emergencies have always been among the top reasons for loans from microfinance institutions and other, often less formal, lenders, but it has rarely been a specific product. A main reason for this is that loan approval takes time and medical expenses are often urgent. However, this is an evolving part of the sector: personal loans specifically for medical emergencies, engineered for quick approval (using alternative credit scoring) and disbursement, and flexible repayment, are being increasingly offered. Generic "top-up"-style emergency loans can also be well-suited for health care expenses, and are frequently used for the purpose. And there are cases of specific loan products designed for certain health needs, such as a pregnancy loan for generally foreseeable antenatal and postnatal expenses.

However, using credit for health care needs can be a poor match because major health events (particularly for a household income-earner) often feature large shocks on both the expense and income sides. Taking on a large loan may solve the immediate problem of paying for the necessary care, but at the risk of overindebting and eventually impoverishing the family altogether. For this reason, credit is best reserved for mid-sized health care needs, leaving insurance as the best answer for severe situations.

One important area for credit is rather than responding to health care demand, to focus on the **supply side of healthcare**. Lending to local health care providers that often represent small and medium enterprises (SMEs) allows providers to upgrade the quality of their facilities, supplies and equipment. Such investments can expand the quality and access to health care for the local community and strengthen the economy and employment opportunities at the same time.

Other Financial Products

An alternative commitment device primarily used for recurrent moderate expenses is often called **pre-paid medicine**. Such schemes are generally offered by health care providers or networks thereof, and function very much like insurance except they are not

normally regulated as insurance companies, and anticipate to provide annual care to their members in roughly equal value to the annual contributions they collect. For consumers, it is a commitment device; for providers, it allows them to better forecast and budget their services. Schemes vary greatly from country to country, but they can provide a reasonable alternative to health insurance, albeit to a limited number of people.

Vouchers that enable persons to make use of usually specific (e.g. reproductive health) services aim to strengthen demand for certain health care services in the expectation that (1) supply will follow, and (2) that people will use their voucher where they perceive the best quality of service, thus rewarding good health care providers. Vouchers have the added benefit of increasing awareness among clients of the importance of preventative and maintenance health care. The cost of such vouchers is generally financed by governments or donors.

While rarely designed for health care specifically, relying on **remittances** from family members (whether elsewhere in the country or abroad) is a very common means of paying for health expenses. In most cases, this entails remitting the required funds directly to the family, but payment providers can offer remitters the opportunity to settle health bills directly, thus reducing the risks of the funds being repurposed for other uses.

Non-Financial Products and Value-Added Services

FSPs focused on health care access often seek out ways to improve the health outcomes of their programmes through non-financial means. The most common of these value-added services (VAS) include passing on bulk purchase discounts (access to discounted pharmaceuticals, diagnostics, medical supplies, for example), tele-medicine consultations, health camps, check-ups and screenings, health advice and information materials, and guidance on care providers and their respective specialisations. Such services are not typically charged separately to customers but are financed by the FSP, recognising that improved health outcomes for clients is mutually beneficial.

Interventions intended to **promote healthy behaviour** are a particular class of VAS. Efforts to make health education more effective and thus have greater impact on health outcomes

are harnessing digital communication and gamification. While hand washing and skilled provider-supported childbirth have long been promoted on a stand-alone basis, providers of health-related financial services are increasingly recognising the relevance of these campaigns, especially those that envision promoting their clients' general well-being as opposed to just covering the cost of ill health.

The prevalence of **digital platforms**, including digital financial services, has created important opportunities for cost-effective means of outreach, allowing use of tools like interactive voice systems and chatbots. And this has positive knock-on effects: low-income customers are increasingly familiar with these tools and platforms, which facilitate connections between clients, health and finance providers, make delivery of health information more cost-effective (and safer - particularly relevant during Covid-19), and even allow consumers to publicly rate the health care they've received.

Loyalty schemes are ways that loyal customers of a product or platform - for example mobile data customers - are rewarded with basic levels of health insurance, a way to 'nudge' and inculcate acceptance of insurance and mutually benefit the network operator, the insurer, the health provider, financial provider - and the client. Insurance can also be given within FSPs to their clients, to reward savings activity for example by giving depositors free insurance.

Because different products answer different needs, a holistic programme that **combines financial products with VAS** can be substantially more effective - and also less costly - than a stand-alone health care finance product. For example, insurance may combine medical savings accounts and tele-health products as a way of encouraging preventative care and early diagnosis, thus lowering the overall cost of care.

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