Do Spouses Make Claims? Health Seeking and Microfinance *

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Abstract

This paper analyzes how microfinance and health seeking interact. Even when borrowers and their spouses have the exactly the same health insurance coverage, we find that spouses are significantly less likely to file for insurance claims. Further, there is a gender difference among spouses: husbands of female borrowers are more likely to file claims than wives of male borrowers. We explore several potential explanations for these differences.

1 Introduction

Even though health risks are a major component of household vulnerability, most people in developing countries have no formal health insurance. This is slowly changing however with recent growth in privately provided health insurance, particularly in India (Roth et al (7)). Many such insurance programs are run by microfinance institutions that use their experience of delivering credit in rural markets to also market insurance. This recent development in micro-insurance has been little studied despite its potential (Morduch (6)).

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In this paper we analyze the determinants of health insurance claims. The data is from a prominent microfinance institution in India that requires borrowers and their spouses to purchase health insurance when the loan is given. A key feature of our dataset is the 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 differences in claim behavior must be related either to differences in underlying health or to differences in health-seeking behavior.

This paper analyzes how microfinance and health seeking interact. Our main findings are (a) borrowers are signficantly more likely to file claims than their spouses and (b) wives of male borrowers are significantly less likely to file claims than husbands of female borrowers. We propose several alternative stories to explain this findings. One plausible hypothesis is that borrowers are more likely to file claims because the very skills that make them borrowers (instead of their spouses) are useful in filing health insurance claims and in navigating the hospital system.

Our paper contributes to a literature on gender differences in health seeking (Santow (8)). Even if health insurance is required for men and women, this literature suggests that women would be systematically less likely to file claims. We find such a gender difference among spouses of microfinance borrowers but not among borrowers themselves.

Our paper also contributes to a small literature that analyzes female empowerment in light of microcredit interventions. Women's empowerment in the household is hard to measure or define. In our paper, we argue that a woman's decision making ability in the household and her access to information from her husband are measures of empowerment. (Our evidence casts some doubt on empowerment based explanations of the patterns we find in the data). Other studies use physical mobility of women or control over the use of the loan (Hashemi et al (3), Goetz and Sengupta (2)), or contraceptive use (Steele et al (9)) as indicators of empowerment. While much of this research is on microfinance programs that typically exclude men, both men and women can take loans in our study.

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 male and female spouses. When microloans are targeted to women, such a rich comparison is not possible.

Outline

Institutional details and a summary of the dataset is in Section 2. The selection issues involved and the main hypotheses that we plan to test are in section 3. We discuss our results in section 4.

2 Institutional Background and Data

The Indian government has taken a proactive role in extending microinsurance to underserved areas Through a 2002 regulation, the government requires private insurance firms to sell a fraction of their insurance policies in rural areas and imposes fines if they do not. Consequently several private insurance firms have set up partnerships with microfinance institutions (MFIs) to meet the government imposed quotas, (Roth et al, (7)). 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; 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 on its loans. Men and women are both eligible to take loans. The MFI prohibits a household from taking multiple loans – so a husband or his wife may take a loan, but not both.

The health insurance program started in May 2005 and was substantially extended in May 2006. 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. The maximum benefit levels were fixed: Rs 1500 for up to 5 days spent at the hospital, Rs. 10,000 for critical illness and Rs. 25,000 for permanent accident. The annual

premium was fixed regardless of borrower age, sex or health history (since the insurance was offered as a group plan).

Starting May 1, 2006 insurance coverage was also required for the spouses of any loan recipients. In other words, borrowers who took a loan after May 1, 2006 and their spouses were required to carry health insurance (provided they met the age requirements). The premium for each individual was Rs. 76. The benefit levels were unchanged but coverage was extended to (a) cover certain pre-existing conditions that had been excluded initially and (b) cover first year exemptions.

We restrict attention to borrowers and their spouses who received insurance starting on May 1, 2006 or later. Our sample includes 279, 214 individuals whose health insurance coverage started on or after May 1, 2006. Of these, half are male and half are female. Approximately 54 percent (151216 individuals) are borrowers and the rest are spouses. The average age is 35 years (Table 1).

We have loan details only for borrowers and not for their spouses. The average loan size is Rs. 10, 428 and is paid in 16 installments (Table 1). The reported activities for which the loan are taken are in Table 2. Dairy projects are twice as popular among men, while shopkeeping is twice as popular among women borrowers. These are the two most prevalent uses for loans (though there is also a substantial uncategorized component) Only 9 percent of the loans are taken for cultivation.

The sample includes individuals who are 'joiners' and 'renewers'. Joiners are first-time borrowers and their spouses. Renewers are returning borrowers and their spouses. 10 percent of the individuals in the sample are joiners and the remaining 90 percent are renewers. About half of the joiners are male and 54 percent of the joiners are borrowers (just as in the sample as a whole).

We measure length of coverage as the number of days between start date of coverage and the end date or May 31, 2007 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. The mean length of coverage is 188 days. Coverage ranges from 1 day (for a borrower and his

spouse who took a loan on May 30, 2007 to 11 months (borrowers and their spouses who took a loan in early May 2006).

Figure 2 compares age distributions for borrowers and spouses. Even though male and female borrowers have similar age distributions (figure 2*a*), male spouses are significantly older than female spouses (figure 2*b*). 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 (age distributions for male and female borowers are equal) but reject the null for the age distributions of male and female spouses. We also compare the age distributions of male borrowers and female borrowers. While male borrowers are slightly younger than female borrowers, the difference is not very statistically significant.

A total of 4238 claims were filed between May 1, 2006 and May 31, 2007 by the individuals in our sample. The claims data contain information on the illness of the claimant, the date when the hospitalization occurred and the amout of the claim.

The average settled claim is Rs. 1238 (Table 3). The monthly claim-to-coverage ratio is calculated as the number of claims filed in a particular month as a fraction of the number of individuals covered in a particular month. The mean for the 13 months in our sample is 0.8 percent.

Figure 1 plots the claim-to-coverage ratio over time. MFI told us that the increase in the proportion of claims filed in August and September of 2006 was due to the Chikungunya fever outbreak. Malvankar et al ((4)) details the deficiencies in the government's response to this outbreak.

The reasons for hospitalization that are reported on the claim forms are typically quite uninformative (Figure 3). Sickness and fever as making up half the claims filed). Spouses are more likely to report uninformative illness categories.

The claims ratio for the sample as a whole is approximately 13 percent. This is calculated as average claims of Rs. 10.05 (Table 3) as a fraction of the Rs. 76 premium collected. While the MFI does seem to have an extremely low claims ratio, the costs of

providing rural insurance are usually very high. Since we do not know the costs of providing insurance for the MFI in our study, we do not estimate the extent of profits for the MFI (or for the insurance firm that carries the risk).

While claim ratios for microinsurance can vary substantially, low claims ratios are not uncommon. Manje (5) reports claim ratios of 9 percent, 10 percent, 18 percent and 48 percent for four MFIs that offer life insurance in Zambia in 2004. Ahmed et al calculate claims ratios of 7 percent for a Grameen Bank health insurance program and 55 percent for Bangladesh Rural Advancement Committee (BRAC) health insurance program in 2004. Interestingly both programs reported substantial losses: after expenses were taken into account, total expenditures were roughly three to four times as high as total (premium) income.

Profit estimates from insurance firms or their partners (the MFIs) are hard to come by. The most detailed numbers available are from a case study of ASA's life insurance in South India (Roth et al (7)). ASA is a life insurance agent for three insurance firms in 2004. ASA collected Rs. 125 in annual life insurance premiums per policy, retained Rs. 89 in premiums to cover its costs for two of its commercial partners, and Rs. 75 for the third insurance firm, and spent Rs. 81 on its expenses. On average then, ASA made little profit. One of the insurance firms reported a healthy 19.5 percent as extra profits (after deducting claim payouts, administrative expenses and a basic profit assumption).

3 Hypotheses

Our aim in this paper is to test if there are differences in the probability of filing claims for men and women, for borrowers and spouses, and for sex differences among borrowers or among spouses. The following table gives an idea of the various potential predictions. The probability of filing claims for each type of borrower is denoted (so mb denotes the probability that a male borrower will file a claim, etc.)

Probability of filing a claim	All	Males	Females
All		m	f
Borrowers	b	mb	fb
Spouses	s	ms	fs

So for instance, we can consider theories that would predict male-female differences in the probability of filing a claim $m - f$ or borrower-spouse differences $(b - s)$. Alternatively, the theories may only predict differences between female borrowers and female spouses $fb - fs$, or between male borrowers and their spouses $mb - fs$ and so on.

In order to understand the selection issues here it is useful to start with a hypothetical experiment. Suppose that there there is a population of males and females, and they are paired at random. Suppose a fraction of individuals chosen at random are given both loans and health insurance. Then half the borrowers will be male and half will be female. Next suppose that health insurance is extended from borrowers to their spouses as well. In such a situation there may very well be gender differences ($m \neq f$ in the table above) because men and women may be differentially susceptible to sickeness. But the randomness should ensure no borrower-spouse differences ($b = s$ in table above). Nor any borrower/spouse differences controlling for gender ($mb = ms$ and $fb = fs$)

In our study there is non-random selection at two levels. First, there could be deliberate matching when men and women are married. Second, and more crucially, there is likely to be selection within couples into which partner takes a loan. Before May 2006 we would expect that sicker household members may decide to become borrowers precisely because they have a higher value of health insurance. Since both the borrower and the spouse are equally covered by health insurance after May 2006, however, there is unlikely to be selection based on the health insurance offered. It is for this reason that we restrict our sample to those borrowers and their spouses who obtained health insurance coverage after May 2006.

We shall distinguish between two types of hypotheses. Health hypotheses for patterns in the data are based on unobserved health differences. Health seeking hypotheses are

based on unobserved differences in the propensity to seek health care, not on underlying health differences. (We will not attempt to be exhaustive here; instead we simply list a series of hypotheses that we can return to on closer examination of the results).

Gender Differences

We first discuss health hypotheses for why we might see gender differences in claim probabilities. The first is a health hypothesis for why $m > f$ or $f > m$. The second is a health seeking hypothesis for why we might expect $m > f$.

Gender differences in morbidity Men and women may simply different susceptibility to disease or accidents. Two extreme examples for when we might expect differences is claim behavior between men and women based on their morbidity are: (a) In a context where childbirth is a major reason for hospitalization, we might expect $f > m$. (b) In a context where men are disproportionately affected by violence, we might expect $m > f$.

Men make decisions Women, particularly younger women often do not have much say in their own health decisions in India (Bloom et al (1)). Instead, husbands, even mother-in-laws make health expenditure decisions for them. The simplest implication of this health-seeking difference would be male/female differences in the probability of filing claims, i.e. $m > f$ and even $mb > fb$, $ms > fs$.

Borrower-Spouse Differences

Next are two health hypotheses for borrower spouse differences. The first predicts that $b < s$. the second that $b > s$.

Healthier People Borrow It is natural to imagine that the healthier spouse in a couple selects to be a borrower (while the sicklier spouse does not). For instance, one might expect that the healthier household member has higher productivity (human

capital) or higher repayment capability (eg. future credit needs, susceptibility to group sanctions). This health explanation would predict that borrowers are less likely to file claims than their spouses.

Borrowing Makes You Sick Imagine that borrowers are more prone to accidents or to disease than their spouses because of the nature of their enterprises. Then $b > s$.

Finally we outline two health seeking hypotheses that predict differences between borrowers and spouses:

Borrowers make decisions Bargaining power within the household may be reflected in an individual's decision to seek health care. Suppose women who have higher bargaining power within the household become borrowers, while women with little bargaining power do not borrow. Similarly with men. Then borrowers would seek health care more than spouses, $b > s$.

Skilled spouses become borrowers Clients may lack the financial sophistication necessary to understand the benefits from insurance. Further, filling out health insurance forms involves an ability to navigate the system and get the medical professionals to sign off on claim forms. Individuals with these (entrepreneurial-like) skills and/or financial sophistication are also more likely to become borrowers. Such differences in selection would predict $b > s$.

Gendered Borrower-Spouse Differences

Finally, we can imagine somewhat more refined predictions that may generate gender differences among spouses but not among borrowers. Here are three such hypotheses:

Sickly male spouses This is a health hypothesis; a variant on "borrowing makes you sick." Suppose the wives of male borrowers stay at home (with less exposure to disease or illness) while the husbands of female borrowers have outside work opportunities that increase their hospitalization risks. That would imply that $ms > fs$

Households differ This is a health-seeking hypothesis; a variant on "borrowers make decisions." Suppose that there are two kinds of households; those in which women have some say in decision making and those in which they do not. Women only get to borrow in the former households; men always borrow in the latter. This would imply that the gap in claim probabilities between male borrowers and female spouses is higher than that between female borrowers and male spouses, $mb - fs > fb - ms$.

Males hide their loans This is another health-seeking hypothesis closely related to decision making differences. Borrowers may not always share their information about coverage with their spouses. In particular, suppose male borrowers hide their loans from their wives because they would like to divert borrowed funds to private uses (e.g. alcohol) from the household pot. In contrast, if female borrowers make investments in public household goods, then the implication is that $fb = ms$ but $mb > fs$. This would imply then that $fb > fs$ and $ms > fs$.

Gender differences in skills This health seeking hypothesis is an extension of "skilled spouses become borrowers." In that hypothesis the intra household distribution of skills determined who become a borrower and who did not. Suppose in addition that men are generally more skilled than women (financially sophisticated, able to navigate the system). This would imply $mb > fb$ and $ms > fs$.

4 Results and Interpretations

As a prelude, note that the claims to coverage ratios are slightly higher for males than for females and higher for borrowers than for spouses (Table 3). There no difference between male and female borrowers but claims to coverage ratios are higher for male spouses than for female spouses (Table 4). These patterns are also evident from Figure 1.

We turn to the estimates from a probit regression in Table 5 which illustrate our main results. Consider first the baseline regression in column (3).

1. Females are as likely to file claims as males (the marginal effect of the female dummy is not significantly different from 0). In terms of our notation, $m = f$

2. Spouses are 0.5 percent less likely to file claims than borrowers. So $b > s$.

3. Female spouses are 0.8 percent less likely to file claims than male spouses (adding the marginal effect of the spouse dummy and on the female spouse dummy). In terms of our notation, $ms > fs$

4. Female spouses are 0.3 percent less likely to file claims than female borrowers. So $fb > fs$

Finding 1 then contradicts both the hypotheses that predict gender differences. It is not the case that men are sicklier than women (or that women are sicklier than men). Further, the simple story in which men make decisions and prevent their wives from seeking health care is also rejected.

Finding 2 contradicts the "healthier people borrow" explanation. Findings 2 and 3 taken together contradict the other borrower-spouse explanations in which there are differences between borrowers and spouses but no gender differences. So we can reject borrowing makes you sick, borrowers make decisions and skilled spouses become borrowers. We are then left with the gendered borrower-spouse hypotheses discussed above.

These conditional probabilities in column (3) do not control for several other factors that may influence an individual's decision to file claims. Controlling for age is especially important since the age discrepancies (figure 2) between male and female spouses could potentially explain finding 2. In the next three sets of regressions we add controls for coverage length, age and joiner (one at a time). Our intention is to see if the basic results are robust to such inclusions. (Note also that each regression in Table 5 contains branch level fixed effects to control for unobserved variation across different parts of India).

Our findings from adding these controls are:

5. The probability of filing a claim should increase in the length of coverage, since the

likelihood of hospitalization must increase over time. An increase in 100 days of coverage increase the probability of filing claims by a small but significant 0.002.percent.

6. Older people are more likely to file claims as they are presumably sicker. As expected an increase in 1 year in the age of an individual increases the probability of filing claims by 0.04 percent and this is even slightly exponential (the squared term is small and signficant).

7. Joiners are 0.5 percent less likely to file claims than renewers.

8. Interaction terms are insignificant in columns (5), (8), (10), (11).

On the whole we find that these basic four results are remarkably robust to the controls. If anything the controls widen the gap between borrowers and spouses slightly to 0.6 or 0.7 percent.

Finally, we offer some preliminary thoughts on the four gendered borrower-spouse hypotheses discussed above. One way to test the "households differ" and the "males hide their loans" hypotheses for the patterns we observe is to check if older women, particular older female spouses, have an increase probability of filing claims. (In India, older women gain status because they have given birth – this gain in status and hence in bargaining power within the household is likely to be higher for female spouses of male borrowers). We test this in column (8). The lack of significance in the triple interaction term (age_female_spouse) casts doubt on these hypotheses.

This leaves us with the "sickly male spouses" and the "gender differences in skills" hypotheses. The former is a health explanation, while the latter is a health-seeking explanation.

The "sickly male spouses" hypothesis is hard to reconcile with finding 8. We find there is no significant change in the gap between claim probabilities of borrowers and their spouses (the interaction term joiner*spouse is insignificant in column 10). The timing of insurance provision suggests that the gap between borrowers and spouses among renewers

would be higher than among joiners because a fraction of renewers took loans when only the borrower but not the spouse was insured. .

The "gender differences in skills" explanation is easier to reconcile with findings 7 and 8. If microfinance either (a) selected more skilled borrowers or (b) treated borrowers to make them more skilled, then we would expect that first-time borrowers are less likely to file claims than renewing borrowers. This would match finding 7. Further, if the initial households that selected into microfinance were more skilled than those that selected in later, that would also explain the lack of significance in the interaction term

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Figure 1: Claims to Coverage Ratio - By gender, spouse and borrower

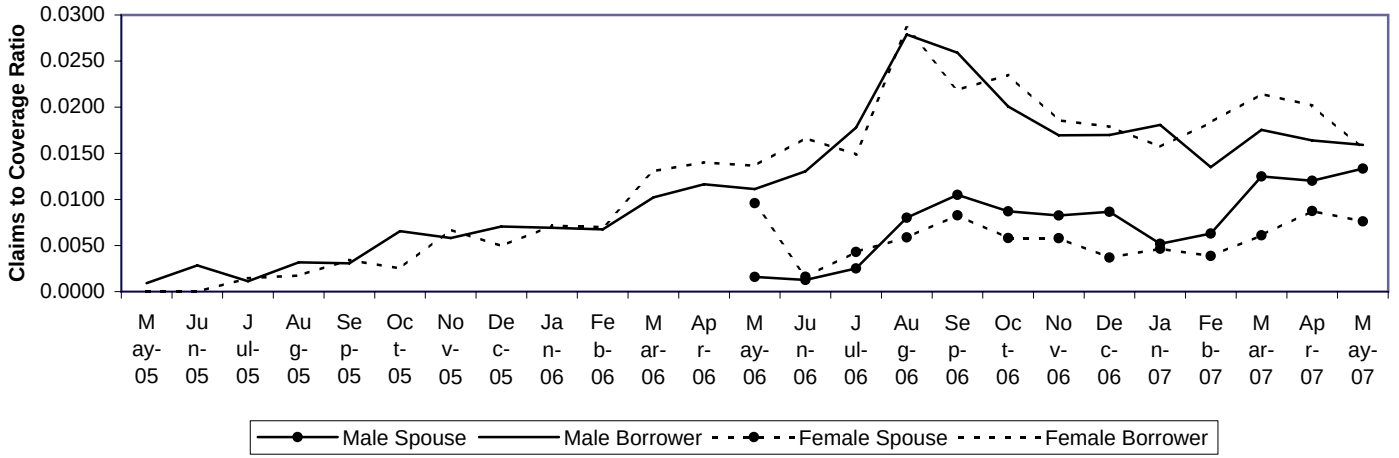

Figure 2a: Age distribution of Borrowers vs. Spouses

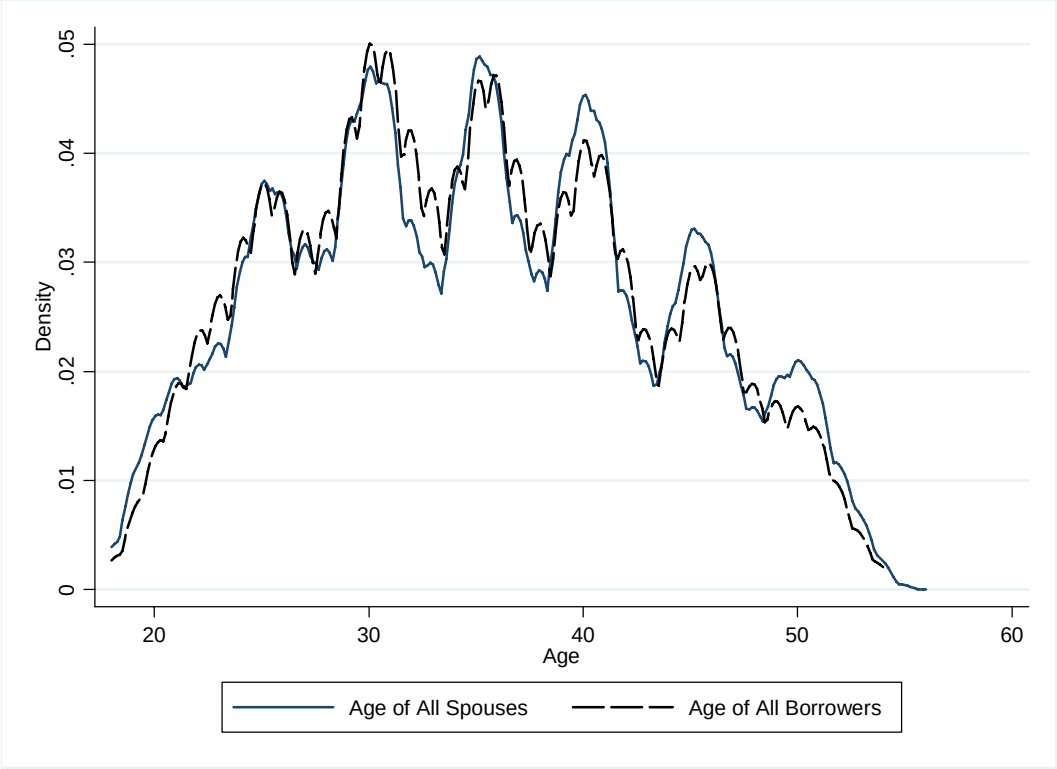

Figure 2b: Age distribution of Male vs. Female Spouses

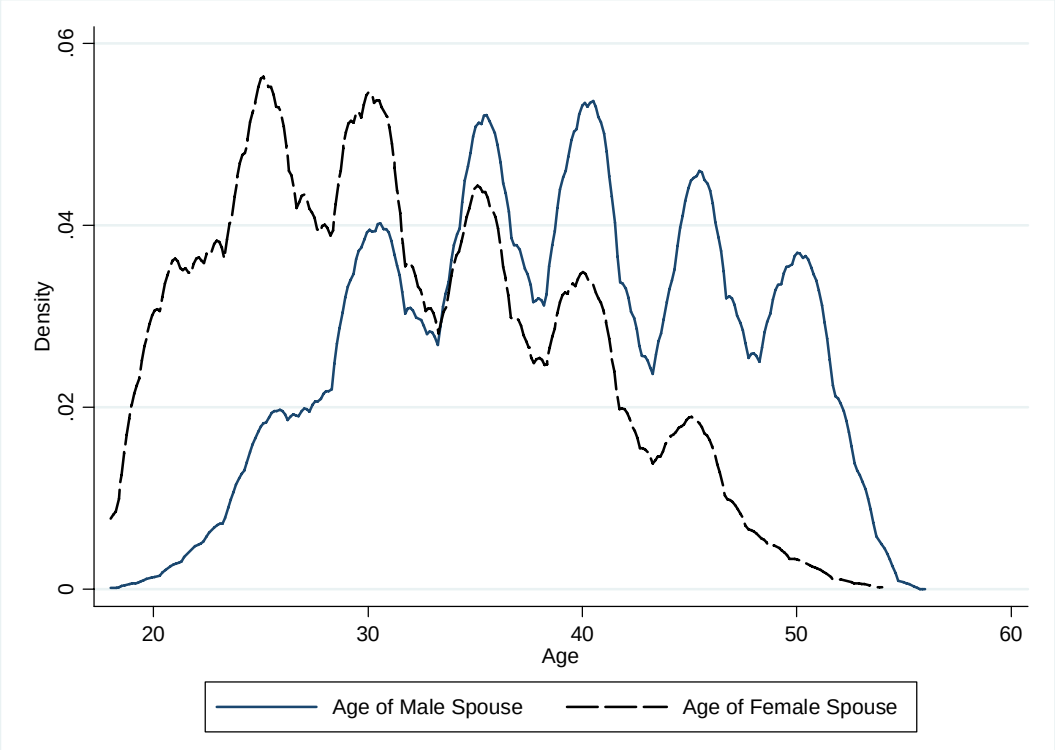

Figure 2c: Age distribution of Male vs. Female Borrowers

Figure 3: Illness breakup: Spouses vs. Borrowers

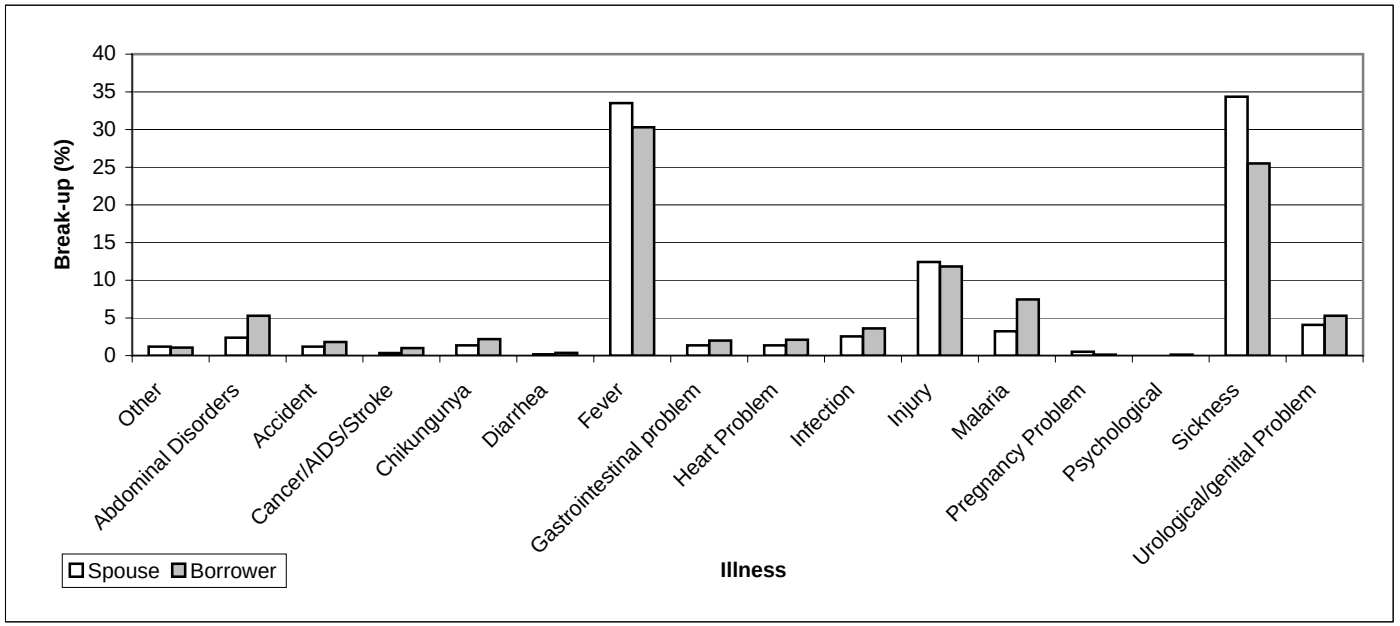

Table 1: Summary Statistics

	Mean	Standard Deviation	Minimum	Maximum	No. of observations
Female	0.50	0.50	0	1	279,214
Spouse	0.46	0.50	0	1	279,214
Female*Spouse	0.22	0.42	0	1	279,214
Coverage length (Days)	187.58	110.70	1	394	276,044
Age (Years)	34.98	8.45	18	56	279,214
Joiner	0.10	0.29	0	1	279,214
Loan Size (Rs)	10427.51	4166.12	3000	50000	151,216
No. of installments	15.98	5.62	2	36	151,216

Note: Loan size and coverage information are only available for the 151216 borrowers who have health insurance coverage after May 2006 (and not for their spouses)

Table 2: Loan Activity (percentage)

Loan Activity	Male Borrower	Female Borrower	All
Bamboo	0.5	0.2	0.7
Cultivation	3.2	5.6	8.9
Dairy	18.1	9.6	27.8
Fish	0.2	0.2	0.3
General	9.6	0.3	9.9
Livestock	1.4	1.4	2.8
Others	8.8	15.1	23.9
Shop	7.3	13.8	21.1
Small business	1.8	2.7	4.6
Trading	0.0	0.0	0.1
Misc.	0.0	0.0	0.0
Total Count	51.0	49.0	100.0

Total number of observations are 151216 borrowers who have health insurance coverage after May 2006

Table 3: Claims and Benefits for Males/Females, Borrowers/Spouses (Means)

	All	Male/Female			Borrower/Spouse		
		Males	Females	Difference	Borrower	Spouse	Difference
Claim-to-coverage ratio	0.0079	0.0081	0.0075	0.0006	0.0106	0.0046	0.0060
				(0.00033)**			(0.00033)**
Settled Claims (Rs.)	1277.97	1280.20	1282.34	-2.14	1275.38	1285.06	-9.68
				(13.36)			(15.01)
Annual Benefit (Rs.)	10.05	10.34	9.58	0.75	13.56	5.90	7.66
				(0.43841)**			(0.44114)**

Note: Claim to coverage ratio is computed by dividing claims by coverage. Annual Benefit is row 1 times row 2
** significant at 5%

Table 4: Claims and Benefits for Borrowers and Spouses by Gender

	Borrower			Spouse		
	Male Borrowers	**Female Borrowers**	**Difference**	**Male Spouse**	**Female Spouses**	**Difference**
Claim-to-coverage ratio	0.0104	0.0107	-0.0003	0.0055	0.0035	0.0019
			(0.00052)			(0.00037)**
Settled Claims (Rs.)	1279.64	1277.37	2.27	1281.40	1300.73	-19.33
			(15.70)			(26.15)
Benefit (Rs.)	13.29	13.63	-0.34	7.00	4.61	2.38
			(0.69126)			(0.49701)**

Note: Claim to coverage ratio is computed by dividing claims by coverage. Annual Benefit is row 1 times row 2
** significant at 5%

Table 5: Probit (Marginal Effects)

	-1	-2	-3	-4	-5	-6	-7	-8	-9	-10	-11
						FiledAClaim					
Female dummy	-0.001		0.0002	0.0004	0.0002	0.0004	0.0004	0.001	0.0004	0.0004	0.001
	-1.81		-0.54	-1.34	-0.49	-1.27	-1.19	-0.47	-1.21	-1.18	-0.42
Spouse dummy		-0.006	-0.005	-0.005	-0.006	-0.007	-0.007	-0.007	-0.007	-0.007	-0.007
		(17.82)**	(10.20)**	(9.65)**	(4.35)**	(10.60)**	(10.63)**	(10.52)**	(10.62)**	(10.69)**	(4.63)**
Female*Spouse			-0.003	-0.003	-0.003	-0.002	-0.002	-0.003	-0.002	-0.003	-0.003
			(4.56)**	(5.26)**	(3.25)**	(3.79)**	(3.71)**	-1.31	(3.70)**	(3.09)**	(3.45)**
Coverage length				0.00002	0.00002	0.00002	0.00002	0.00002	0.00002	0.00002	0.00002
				(22.73)**	(13.41)**	(22.72)**	(22.71)**	(22.70)**	(19.38)**	(19.39)**	(11.73)**
Female*Coverage length					0						0
					-0.41						-0.04
Spouse*Coverage length					-0.00002						-0.00002
					-1.75						-1.78
Female*Spouse*Coverage length					0						0
					-0.16						-0.42
Age						0.0001	0.0005	0.0005	0.0004	0.0004	0.0004
						(6.69)**	(3.11)**	(2.92)**	(3.12)**	(3.13)**	(2.93)**
Age2							-5E-06	-0.000005	-0.000004	-0.000004	-0.000004
							(2.30)*	(2.22)*	(2.30)*	(2.31)*	(2.22)*
Female*Age								-0.000007			-0.00006
								-0.19			-0.18
Female*Age*Spouse								0.00001			0
								-0.21			-0.26
Joiner dummy									-0.005	-0.005	-0.005
									(8.64)**	(5.19)**	(5.10)**
Joiner*Female										0.0003	0.0005
										-0.15	-0.19
Joiner*Spouse										0.004	0.003
										-1.34	-1.07
Joiner*Female*Spouse										-0.005	-0.005
										-1.54	-1.47
Observations	279214	279214	279214	279214	279214	279214	279214	279214	279214	279214	279214

Absolute value of z statistics in parentheses; * significant at 5%; ** significant at 1%;

Filedaclaim=1 if a claim was filed before May 31, 2007, =0 otherwise

Coefficient is for discrete change of dummy variable from 0 to 1

Fixed effects are included in all regressions for the 43 branches (across 10 Indian states)