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SHGs AND MICRO-FINANCE : A TALE OF TWO POOR WOMEN IN RURAL TAMIL NADU

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ABSTRACT

Poor households suffer from the problems of low and volatile income, appalling health, and limited access to healthcare services. This makes them highly vulnerable to health shocks whose effect could be devastating. Hefty medical expenses virtually erode out whatever little financial and physical assets poor households accumulate over time through hard toil. Also lack of awareness about health insurance makes the situation even worse. Poverty-stricken households tend to prioritise savings over insurance without realising the need for both. Moreover, as far as critical diseases are concerned, existing health insurance schemes also fail to provide adequate coverage. The stories of Savitha and Suvarna, two poor women from rural Tamil Nadu, are narratives of these crude realities.

Introduction

Poor households not only suffer from income poverty but also lack access to education, finance, healthcare services, etc. The Government of India launched different programmes and schemes to address deprivations in terms of aforementioned dimensions of human well-being. For example, the *Sarva Shiksha Abhiyaan* (SSA) - was launched in the year 2001 to make elementary education for children aged 6-14 years old accessible to all households; Self-Help Group (SHG) - led bank linkage programme was introduced for greater financial inclusion through provisioning of deposits and credit by the National Bank for Agriculture and Rural Development (NABARD) . The SHG Bank Linkage Programme was started as an Action Research Project in 1989 which was the offshoot of at NABARD initiative during 1987 through sanctioning ₹10 lakh to MYRADA as

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seed money assistance for experimenting Credit Management Groups[a]. National Rural Health Mission (NRHM) was implemented in 2005 to improve the health status and access to basic health services of the poor households in rural India.

A quick look at the range of various State and Central government sponsored social and development programmes reveals that little attention has been paid to address the vulnerability of poor households to health shocks. Most of the health insurance schemes rolled out earlier at the State level or national level had several pitfalls and limitations in terms of design and implementation and hence failed to achieve their desired objectives. To address this at a national level, Government of India initiated Rashtriya Swasthya Bima Yojana (RSBY) for the poor households in 2008. At a State-level, below poverty line (BPL) households in Tamil Nadu (Tamil Nadu Health Insurance) and Andhra Pradesh (Rajiv Aarogyasri), two of the southern States of India, are given access to health insurance through a State government sponsored scheme. Lack of health awareness together with low and volatile incomes makes poor households more susceptible to frequent illness and critical diseases some of which often become life threatening. For poor households health shocks bring several adversities. On the one hand, they end up spending money earned through hard work for meeting medical costs and on the other, those poor households, whose breadwinners mostly earn their living from daily labour lose livelihood for not being able to work due to sickness. Many a time, a medical emergency may lead to distress sale of assets created through years of hard toil and small savings. In other words, financial risk from "catastrophic health expenditures" continues to be high (Fan et al., 2011; Selvaraj and Karan, 2012). Using data from the 61st round (July 2004-June 2005) of Consumer Expenditure Survey conducted by NSSO, Shahrawat and Rao (2011) find that out-of-pocket (OOP) health expenses worsens poverty headcount ratio by 3.5 per cent and more so in rural India (3.8 per cent) than in urban India (2.7 per cent)*. Thus at times, health shocks could be so devastating that it can completely jeopardise the future of the poor households.

The Promise of Micro-finance

Despite phenomenal growth of micro-finance in India, financial inclusion remains a distant dream. Poor households still lack access to dependable savings products, credit and insurance. High transaction cost is the biggest challenge practitioners' face in reaching out to the poor. Moreover, poor households and their financial needs are not homogenous across urban and rural India. Starting from the SHG movement to the present micro-finance movement, micro-finance aims to meet only the credit needs of the poor-of course an important need- without offering a holistic solution to their other financial problems. The main objective of micro-finance movement is to create livelihood opportunities for poor women through provisioning of cheaper credit. Access to credit is also expected to empower the women and thereby raise the overall well-being of the poor households. Has this promise been realised? While these are the questions often addressed rigorously in empirical research, the following cases narrate how Savitha and Suvarna, two poor yet ambitious women who had borrowed from MFIs (micro-finance institutions) with a hope to secure a brighter future failed to do so. This could be any poor woman's story who aspires and strives hard despite all odds to emancipate her family from the clutches of poverty.

The Cases

The Story of Savitha : Driving down 45 km from Chennai in early January 2011, we found a sharp

* However, the methodology of this study has some serious limitations due to which such findings may not be very robust.

cut to the right on the main Old Mahabalipuram Road (OMR) that connects Chennai to several cities down South. Mud tracks amidst deceptively green fields with no sign of urbanisation led us to Savitha's dwelling. She had been allotted this small piece of land with a house about four years back by the government of Tamil Nadu as she was identified as a 'below poverty line' (BPL) beneficiary. Savitha recollected that she had migrated to this village, S V Chataram about 17 years back from another interior village in Tamil Nadu. Till about five years back, she used to work as a coolie or as a housemaid but the employment was irregular and her income was abysmally low. She could never meet both ends as her husband never worked or felt the need to contribute to the household's income. Her husband was virtually jobless. Unlike other men of the locality, he was not an alcoholic but used to demand money from her to meet his personal expenses. He never felt a sense of responsibility towards their two children, a boy and a girl. Their son worked as a coolie and earned about ₹ 3,000 per month and their daughter lived away from them after marriage. So, all the responsibilities starting from feeding the family or meeting emergency expenses fell entirely on Savitha.

The arrival of Lalita five years' back, the local person responsible for forming SHGs under the aegis of a local NGO, intrigued Savitha who watched other members in the village forming groups and their gradual progression towards self-employment. Initially she perceived her illiteracy an impediment to joining such groups but the success of some of her peers coupled with an improvement in their families' living standard prompted her to join an SHG three years after micro-finance activities started in her village. Her first loan from the NGO was of ₹ 5,000. She decided to start a petty shop with the help of the loan outside her house. Using a bulk of the loaned money she bought initial inventories for the shop. Savitha hoped to sell these items to her neighbours' as the goods were day-to-day items. However, to her dismay, most of her customers started buying goods on credit! Competition posed by other petty shops and having no unique selling strategy, and her benevolent nature were some apparent reasons for the failure of her business.

However, her failure in business could not quell her penchant for success in life. Hence she took the second loan of ₹ 10,000 and bought a few goats. Typically a good breed goat costs about ₹ 2,500. She used the loan to buy four goats and sold the baby goats every six months. This she found rather profitable. This business picked up steadily and she felt somewhat comfortable at the smell of her first success. Additionally, she also worked under the MGNREGS (Mahatma Gandhi National Rural Employment Guarantee Scheme - a scheme that guarantees 100 days of work to the poor). Wages received from MGNREGA work and profits from goat rearing together with access to low cost foodgrains supplied through fair price shops (another government scheme for the ultra poor) enabled Savitha to provide at least two square meals to her family regularly. Did Savitha save anything for the future? Yes, she did. She compulsorily saved with the NGO. Savitha's son worked as a coolie on a daily wage. So his income was highly irregular. So far so good!

The crisis in her life began in 2009 when her husband was diagnosed with cancer. She ran from pillar to post to arrange a sum of ₹ 50,000 for his treatment. Later on, she was told about the State Chief Minister's Scheme which allowed families like her to get funds up to rupees one lakh for lifestyle diseases. She availed of the same and got her husband admitted in a premier hospital in Chennai but the insurance amount got exhausted very soon. Later on in this financial tyranny, she ended up mortgaging her house for getting a loan of ₹ 1,75,000 at three per cent interest per month. With the help of her and her son's

income, she managed to just pay the interest while the principal amount remained unpaid. Despite all adversitites, Savitha continued treatment of her husband. Thus, a family member's sudden sickness pushed the entire family into a quagmire of poverty, loans and mortgages. How did Savitha then manage her finances?

Having struggled for 17 years with extreme volatilities in income, loan from SHG as well as the government health insurance schemes did not make much of a difference in Savitha's life. When she was about to achieve financial stability, her husband's sudden sickness made it quite arduous for her to achieve that. Savitha was facing the possibility of losing almost everything that she had saved and she was highly likely to fall into a debt trap. The probability of critical illness could be low but when it afflicts one of the family members, the effect is devastating. The only practical solution to this is critical illness insurance. The question that arises now is: can the poor afford the premium of such insurance policy? In this context, it must be noted that the then Chief Minister of Tamil Nadu (M.K Karunanidhi) started an innovative scheme for the BPL households, which in the present form is modified by the present Chief Minister Dr. J. Jayalalitha. The modified Insurance Scheme was launched by the Tamil Nadu Government in 2011 through the United India Insurance Company Ltd (a Public Sector Insurer headquartered at (Chennai) to provide free medical and surgical treatment in government and private hospitals to the members of any family whose annual family income is less than ₹ 72,000 (as certified by the Village Administrative Officers). The Scheme provides coverage for meeting all expenses relating to hospitalisation of beneficiary as defined in the Scope of the Scheme. The main objective of the Scheme is to provide free medical and surgical treatment and quality care in government and private hospitals to the members of eligible families. To achieve the objective of universal healthcare, to provide quality healthcare and easy access to the multi-speciality hospitals by the members of the scheme this priviously provided services for only the highly affordable society. The scheme seeks to provide hospitalisation facility for certain specified ailments / procedures. It privides a coverage up to ₹ 1,00,000 per family per year on a floater basis for the ailments and procedures covered and specified. The coverage amount seems a limitation of the scheme though it is possible to take slightly enhanced coverage amounts too.[b]

However, such scheme seems insufficient for Savitha's needs. Is it a limitation of the scheme or of the way it is being utilised? There are many poor households like that of Savitha's struggling to utilise schemes to save the lives of their near and dear ones.

The Story of Suvarna : Our next stop was Ms Suvarna at Sriperambudur, about 20 km. from Savitha's house. Her house was situated in a rural location, congested and with very poor amenities. Her home was located in a narrow lane without any proper sanitation facility, drinking water, etc. Although everyone was given a colour television by the government, supply of electricity was intermittent. Suvarna lived in a house with concrete roof and walls. Her mother had migrated to that village about 21 years back from another distant village with Suvarna and her brother and had started a flower business. The flower business was doing well.

Over the years, she took an active interest in the flower business and with the help of small loans she was able to expand the business. Suvarna told us with great pride that she was able to reap a profit of ₹ 100-150 per day from the flower business. She was one of the first persons to join a group when SHGs were being formed about seven years back by an NGO.

Her reasons for joining the group were simple. She said that being a semi-literate woman with no assets to mortgage as collateral,

her only source of credit was the local moneylender with whom she had minimal bargaining power. Suvarna also added that her SHG membership had helped her to graduate from small loans to large loans at reasonable rates facilitated by the person at the SHG. Her first savings account started as compulsory deposits with the SHG and that was the first time when she realised that she could save and accomplish what she wanted. This led her to save small sums in a recurring deposit scheme at a nearby branch of State Bank of India, a nationalised bank having largest presence in India. She also started saving money with a post office as well. Suvarna invested the second SHG loan to set up a fruit business for her son. She was quite candid to tell us that she had refused to take the optional health insurance scheme offered by the MFI as she had felt the premium was a waste of money and the benefits to her seemed only marginal. She however had taken a life insurance policy. With her savings, she could make some down payment and took another loan to buy a house worth ₹ 500,000. From penury to asset building, the sky seemed the limit to her then!

However, in 2010, her mother started getting a recurring stomach pain. What started as a routine visit to the doctor followed by tests seemed a never ending affair. Her mother's condition showed no improvement. Suvarna borrowed a sum of ₹ 2,50,000 from friends, moneylenders as well as the SHG to meet her mother's treatment costs. Unfortunately, Suvarna did not receive the Chief Minister's Insurance Scheme card. What made her more worried was the fact that her mother's illness remained undetected in spite of all the hefty expenditure she had incurred. As we talked to her we realised in her voice the imminent pall of gloom and her worry that all the assets she had built up carefully might get eroded completely. With her sick mother, Suvarna was directionless with no health insurance. She had accumulated small sums of money in several forms: with the SHG, banks, post office etc. Though she had been very successful in her business, its expansion, diversification (through her son's fruit business) and in asset building (construction of the house single-handedly) she failed to realise the need for mitigating health shocks by taking appropriate insurance cover.

Policy Implications

The health ministry of Government of India is aiming to achieve Universal Health Coverage (UHC) during the 12th Five Year Plan (2012-2017). From the above narrated cases, it is clear that existing health insurance schemes for the poor and other financial tools are far from being adequate to mitigate financial risks from catastrophic health events. Thus, the need of the hour is not just to universalise healthcare services but to strengthen and improve primary healthcare services for the poor and linking it effectively with secondary healthcare services. This kind of linkage will expedite detection and treatment of catastrophic diseases for the poor households. Early and accurate detection of ailments is not only beneficial for healing but cost-effective as well. As Selvaraj and Karan (2012, p 67) rightly argued, in the current service delivery model "[h]ealthcare is not viewed as a continuum of care, rather seen as a compartmentalised care". The report of the High Level Expert Group (2011, p 111) on UHC also recommend that the "secondary and tertiary care that is provided should be well integrated with primary care to ensure careful management of the long-term well-being of the patient." Building public-private-partnership (PPP) can be a means to achieve effective service delivery as highlighted in a report titled, 'India Healthcare: Inspiring Possibilities, Challenging Journey' released by McKinsey and Company in December 2012. Secondly, government-run insurance schemes must be linked with UHC system. Thirdly, beside generating health awareness and promoting preventive healthcare services, it is also imperative to create greater awareness about the need for health insurance among the poor households.

Conclusion

The narratives of Savitha and Suvarna raise some important questions. One may ask: why did not they opt for health insurance? Suvarna told us that she had felt life insurance gives some assured return whilst health insurance gives no return per se. This finding is perfectly in line with what Collins et al (2010; p 93) found elsewhere in India:"poor households may feel that, given their very small resources, they are better off using general-purpose tools. After all, the insured risk may never occur, in which case insurance premiums give no return…whereas savings become available for other uses." Therefore, steps should be taken to create awareness about preventive healthcare which will attenuate poor households' likelihood of getting afflicted by many common diseases. Another pertinent question to ask at this juncture is the following: can own savings be a substitute for insurance? Our cases show that the answer is no. Both Savitha and Suvarna tried hard against all odds and had made use of the resources provided by the government as well as the NGO (micro-finance) to try to first smooth their consumption and then save whatever amount they could in different forms. It is evident that opportunities in terms of income and savings were more for Suvarna. Was it the choice of her business that made her better off than Savitha? Or was it the market conditions? Could market linkages play a part by the NGO catalysing the process of their income rise? Whatever be the case, Suvarna could save and build her asset (house); however a single medical emergency eroded fruits of her years of hard toil. For many other poor women like Savitha, who mostly work as daily labour, sickness leads to loss of income. What kind of insurance can mitigate this kind of risks that may potentially erode all little savings poor households build over a period of time?

Should poor households diversify between savings and insurance? Or is there a trade-off between them: more savings means lesser money available for buying insurance and vice-versa? Finally, what kind of insurance policy will suit their needs so that the MFI can help them in selecting the right health insurance policy with affordable premium that can minimise their risk from health shocks? These are questions that need to be answered through further research.

Notes

a. http:/www.nabard.org/pdf/report _financial/Chap_VII.pdf
b. http:/www.cmchistn.com/

References

1. Collins. D., Morduch. J., Rutherford. S., and Ruthven. O, (2010), Portfolios of the Poor: How the World's Poor Live On $2 a Day, Permanent Black, Ranikhet, India.

2. Fan, Y Victoria, Anup Karan and Ajay Mahal, (2011), "The Impacts of Aarogyasri Health Insurance in Andhra Pradesh, India", Paper Presented at "Global Health Metrics and Evaluation Conference" held at Seattle between 13-17 June, Abstract Published in the Lancet 2011; Published Online 14 March, DOI:10.1016/S0140-6736(11) 60169-64.

3. High Level Expert Group Report on Universal Health Coverage for India, Planning Commission of India, Government of India, 2011.

4. Mckinsey Report, (2012), "India Healthcare: Inspiring Possibilities, Challenging Journey" available at http://www.mckinsey.com/locations/india/mckinseyonindia/pdf Executive_ Summary_India_Healthcare_Inspiring_pssibilities_and_challenging_journey.pdf accessed on Feb 2, 2013.

5. Selvaraj, S. and Karan, A.K., (2012), "Why Publicly-Financed Health Insurance Schemes Are Ineffective in Providing Financial Risk Protection", *Economic and Political Weekly,* 47 (11), 60-68.

6. Shahrawat and Krishna D Rao, (2011), "Insured Yet Vulnerable: Out-of-Pocket Payments and India's Poor", *Health Policy and Planning,* doi:10.1093/heapol/csr029, 12 April, pp 1-9.