FEASIBILITY STUDY OF INTEGRATED BANKING PRODUCT FOR THE RURAL POOR IN INDIA

Dr Sabita Mahapatra*

Abstract

Financial inclusion refers to the process of ensuring fair, timely and adequate access to saving, credit, and insurance services, payment and remittance facilities, at an affordable cost in a fair and transparent manner by the mainstream institutional players. Studies at national and international level suggest that while opening of bank accounts can be the first step towards financial inclusion of the poor, keeping them connected with the banking system remains a challenge. The present paper attempts to carry a feasibility study in one of the most underdeveloped state in India, to understand the awareness and acceptance of financial service among people below poverty in order to design a customized micro financial product covering health insurance. Based on the self-administered survey it was found that the as needs and demand of the poor for health insurance, depend on local conditions, 'One-size-fits-all' should not be the criterion while designing an integrated micro finance product with micro health insurance being its prime component.

Key words: inclusive growth, financial inclusion, health insurance, and rural poor

* Indian Institute of Management Indore, India

Introduction

Microfinance is a movement whose object is "a world in which as many poor and near-poor households as possible have permanent access to an appropriate range of high quality financial services, including not just credit but also savings, insurance, and fund transfers" (Robert *et al*., 2004). Such a financial system would bring poor people to the mainstream allowing them to contribute actively to their personal economic development (United Nations, 2006). Treasury Committee, House of Commons, UK (2004) views financial inclusion as individual's ability to access appropriate financial products and services. Financial inclusion is usually measured by the percentage of people who have access to bank accounts in the region (Beck & De la Torre, 2006). Scottish Government (2005) views financial inclusion as access for individuals to appropriate financial products and services. Report of the Committee on Financial Inclusion in India, 2008 (Chairman: C.Rangarajan) views financial inclusion as the process of ensuring timely and adequate access to financial credit and services to weaker sections and low income groups at an affordable cost. Financial exclusion by contrast, is the converse of this. Chant Link and Associates, Australia (2004) describes financial exclusion as lack of access to appropriate low cost, fair and safe financial products and services from mainstream providers. Financial exclusion becomes a concern in the community when it applies to lower income consumers those in financial hardship.

Financial inclusion does not begin and end with opening of a bank account. Where bank accounts is claim to be have been opened, verification shows that, these accounts lay dormant. The World Bank study reveals that 40 per cent of the indoor patients borrow money or sell assets to cover hospital expenses while hospitalization impoverishes one fourth of the hospitalized Indian population. The rural poor households are exposed to multi risks like frequently health risks that greatly impact the household's expenses. Livelihood of a poor during old age is a major problem due to inability to work at old age and lack of proper support system. The first option available to meet any contingencies is ones own savings followed by the next option of pledge or sell some household articles or jewelleries to meet their medical emergencies. Innovation in micro health insurance product specially designed for the poor may be a step towards preventing their indebtedness. Relieving the elderly poor from suffering and ensuring that they spend their non-

productive years with dignity calls for a major innovation in designing a micro pension product that would cater to their personalized old age needs.

Many of the generic financial products are unsuitable for the poor and there has not been enough effort put to design products suitable to their specific needs. Keeping in view the life cycle needs of the poor, there is a pressing need for innovation in product development and service delivery in the financial sector to encourage the poor to save. Product development is an essential activity for market responsive financial institutions. Rolling out a cost-effective innovative financial product, therefore, calls for a systematic approach that involves conducting market research to understand the financial needs, and pilot test of the product prototype to analyze the perceived risks. To design any micro health insurance programme in India, the plural nature of health system, like presence of a large fee levying, proportion of premium to be paid by the poor and alignment of incentives needs to be carefully thought out.

Research Methodology

Delivery and design an efficient suitable and sustainable customized micro financial product targeting to poor, presents challenges in understanding a need-based solution accommodating multiple objectives. The present study makes an attempt to understand the financial needs and inter-regional differences among poor. The findings would help in designing an integrated banking product customised to the region specific financial needs. The present study was conducted in the state Orissa was chosen as the area of study as it is considered to be one of the poor states of India, with around 47.15 per cent of its population living below the poverty line. in two locations (a cluster of villages in two blocks) of Eastern and Southern Orissa. A self-administered survey method was used for collection data from 200 respondents selected randomly from Nimapada Block, Puri district and Kukudakhandi Block, Ganjam district based on the human development indices.

Findings of the Study

Findings from almost the entire respondent of both the blocks showed a positive attitude for micro health insurance. Most of the respondent indicated a need for health coverage for self, spouse and children. Around 59 % of the respondents in Nimapada block were willing to pay a premium of 325 rupees towards the micro health insurance (MHI) product as compared to around 68 % in Kukudakhandi block. 26 % of the respondents in Nimapada block were prepared to pay

200 rupees as premium in comparison to the 13 % in Kukudakhandi block. Around one-seventh of the respondents of both the blocks were willing to pay 500 rupees as premium for the micro health insurance product. Majority of the respondent were willing to pay premium annually. Though few respondents of both the blocks also opted to pay premium ones in every six month.

Almost all respondent in both the blocks express their acceptance for the idea of integrated banking product that would cater to their savings, health care coverage and old age security needs. Of the respondents interested to avail the product, around 86 % of the sample population of Nimapada block showed willingness to contribute in the range of 51-100 rupees per month (around 612-1200 rupees per annum) as compared to 44 % in the Kukudakhandi block towards the integrated banking product. Around 52 % of the respondents in Kukudakhandi block were willing to contribute 101-150 rupees per month (1212- 1800 rupees per annum), in comparison to only 11 % in Nimapada block. Around 81 % of the respondent in Kukudakhandi block prefer to pay from their own savings towards the integrated product, whereas around 45 % of the respondent in Nimapada block prefer to pay from their sale proceeds from farm produce due to the latter being dependence on farming sector.

Most of the respondents of Nimapada block were aware of non-government organization (NGO) working in the area as the NGOs were instrumental in forming self help groups among the poor women in the area. In Kukudakhandi block, around 67 % were not aware of any NGO/MFI working in their area. More than 99 % of the respondent in both the block were not aware of any agent of bank/financial institution or business facilitator/correspondent working in their area. It is noteworthy to mention that mobile penetration seems to be very high with 78 % in Nimapada block with only 34 % of the respondent having savings account in bank/financial institution compared to 47 % in Kukudakhandi block with 45 % have savings account in bank/financial institution. It is noteworthy to mention that around 92 % of the respondent in Nimapada block as compared to 48 % in Kukudakhandi block were ready to get information on financial services through mobile.

SHGs were the accepted delivery agent among 90 % of the respondent in Nimapada block while 53 % and 33 per cent of the respondents in Kukudakhandi block prefer post office staff and

ASHA[1] as the prefer delivery agent respectively. 85 % of respondent of Nimapada block prefer SHGs as they were comfortable with them to discuss at their convenient time while 81 % of the respondent in Kudakhandi block trusted post office staff and ASHA as their *Bittiya Sakhas*.

82 % and 94 % of the respondent in both Nimapada and Kukudakhandi block were not aware of the initiatives on financial inclusion, like no-frills account, general credit card. 74 % of the respondent in Kukudakhandi block were not aware of small saving financial scheme of micro health insurance, 97 % were not aware of micro health insurance while 92 % were not aware of general credit card. Respondent of Nimapada block, were however, aware of small savings through SHGs and micro health insurance. Awareness about general credit card was also abysmally low among the respondent in Nimapada block.

Around 99 % of the respondents in Nimapada block prefer NGO/MFI working in their area, while ASHAs was preferred by respondents of Kudakhandi block as awareness spreaders/*Gyana Sakhas*. 96 % respondents from Nimapada block preferred group meetings/discussions with financial service provider as the media for dissemination of information. Television followed by group meetings/discussions with financial service provider seemed to be preferred by respondents of Kudakhandi block with 60 % and 29 % respectively. Regional channel was most preferred TV channel while FM and Akashwani seems to be preferred radio channels among respondent of both the blocks.

Conclusion and Suggestions

The findings of this study revealed the fact that the poor have an understanding about the benefits of health insurance and are willing to set aside a small sum of money every year as premium to avoid indebtedness in future. However, the findings also reflected selected regional variation in financial profile, borrowing pattern during illness episodes, pattern of health care expenses, acceptance of micro health insurance and integrated banking product and difference in terms of financial awareness, preferred agent and media.

In view of the fact that integrated banking product and customised micro health insurance product will have very high level of acceptance among the poor, introducing such products may

[1] ASHA-One of the key components of the National Rural Health Mission is to provide every village in the country with a trained female community health activist – 'ASHA' or Accredited Social Health Activist. Selected from the village itself and accountable to it, the ASHA are trained to work as an interface between the community and the public health system. For more details, please see the web link-http://mohfw.nic.in/NRHM/asha.htm#abt

create a vast opportunity for the insurance providers and bankers. In government sponsored MHI schemes like, Rashtriya Swasthya Bima Yojana (RSBY), Union Government and the concerned State Government pay for the premium while the beneficiary pay only 20 rupees for the smart card at one-time. Willingness to pay 325 rupees per annum towards MHI, as revealed by the study, thus can be an encouraging factor for the revenue of the government. Introduction of such micro health insurance product may also have an indirect impact on the government's healthcare facilities. For the poor who are willing to pay a very small amount like Rs 50 as premium, coverage of wage loss, conveyance and out of pocket expenditure through health insurance would encourage them to avail treatment from government health care facilities (as Government takes care of other treatment related expenses). For government, this would lead to increase use of primary health care centers (PHCs) and government hospitals. This may also help to change the negative perception of people regarding the quality of care available at government healthcare facilities. Especially for places like Kukudakhandi block, where the poor avoid visiting government healthcare center and opt for expensive private healthcare, even at the risk of having to raise loans, they may seek medical help at PHCs willingly. Increased attendance at these facilities may also motivate doctors and support staff to deliver better service, like in the case of the community based health insurance (CHI) scheme provided by Karuna Trust. Timely treatment for ailments, combined with the security of not having to lose wages will definitely contribute to a healthier population.

An integrated banking product for the rural poor needs to be designed in the following lines:

Based on the willingness to contribute and pay towards MHI, the premium towards MHI can get deducted from the amount saved in the bank after certain period. The rest of the contribution can be saved in their corpus fund from which certain % may be transferred towards the pension fund while certain proportion will get saved and invested in a recurring deposit account opened in their names. Of the balance available in the recurring deposit account, the risk-taking individuals may be given an option of investing certain amount per annum in micro mutual fund depending on their choice and convenience. Saving in recurring deposit account may help the poor to meet the credit emergencies for events like, children's marriage, renovation of house, purchase of an immovable asset, etc. To encourage savings, individuals with more saving potential may be given an incentive in terms of increased rate of interest.

Delivery of such banking products through SHG or Auxiliary Nurse Midwives and Anganwadi workers can also utilized, as they are already accepted channels in the communities. Effort should be made to develop awareness about NGOs/MFIs operating in the area and about the financial inclusion initiatives. This would call for financial literacy for introducing micro health insurance and integrated banking product in the area. This can be achieved though customized financial literacy campaigns through preferred medium that might include opening of no-frills account with zero/minimum balance, relaxation of customer guidelines, overdraft facility through general credit card scheme that are not known to the poor mass and the NGOs working in the area. Thus financial inclusion in true sense will go a long way in making rural poor self-sufficient and self-confident by empowering them financially.

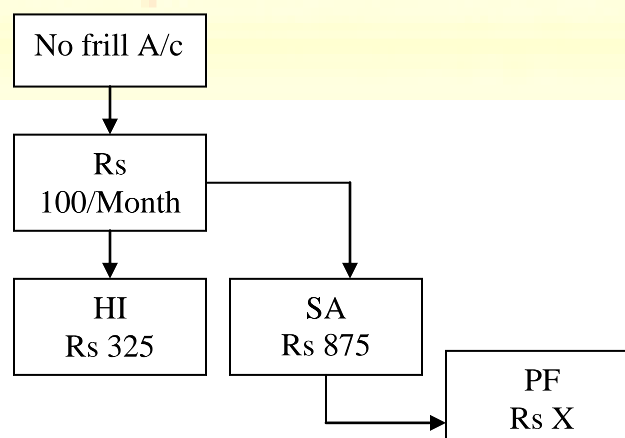
How to operationalize the Product?

Step I: An individual 'X' opens a no-frills account in a bank.

Step II- He/she deposits Rs 100/- per month towards the integrated product (most accepted amount as per the study).

Step III- At the end of 4th month, he will have Rs 400/- in his bank account. Rs 325/-(that's the amount most of the respondents have agreed to pay towards health insurance), will go to the insurance provider towards his health insurance.

Step IV- Rs 875/- (Rs 1200/-minus Rs 325/-) will get accumulated in his/her bank account by the end of the year. And this amount can go to his pension funds for his old age security needs. Here the bank can act as a fund manager and manage his fund so that at the age of 60 yrs, he/she can get a specific amount as pension.



Challenges Ahead

As the concept is new and primarily supply driven, there is a need to spread awareness through community-based organisations like NGOs, MFIs, ASHA workers. The benefit design and the related procedures need to be simple keeping in view the high level of illiteracy among the poor. The insurance provider needs to be very efficient so that the claim process for the micro health insurance is speedy and has no administrative delays. This would demand a high order of synergy of public-private partnership in health care. Gram Panchayats can play an important role by providing financial assistance for paying premiums through SHGs to members who cannot pay. Involvement of people in the grass root level like, ASHAs, SHG members, post office staff as delivery agents of such integrated and innovative products can help in spreading awareness on availability of financial services among the rural poor. Technology with high penetration of mobile phones as per the findings of the study can play a significant role in reducing the costs of making transactions thereby deepening financial inclusion. Indian technology giants, like Infosys, Wipro, Tata Consultancy Services, may be play role of channel partner to put in their expertise in encouraging technology enabled financial inclusion in a big way.

References

1. Chakrabarty K. C. Dr, Deputy Governor, Reserve Bank of India, 17 June (2010). Financial Deepening by putting Financial Inclusion Campaign into Mission Mode 23rd Skoch Summit in Mumbai.

2. David M. Dror, Ralf Radermacher and Ruth Koren, September 26, (2007). "Willingness to pay for Health Insurance among Rural and Poor Persons: Field Evidence from Seven Micro Health Insurance Units in India.

3. Robert Peck Christen, Richard Rosenberg and Veena Jayadeva, 2004. Financial institutions with a double-bottom line: implications for the future of microfinance. CGAP Occasional Paper, July 2004, pp. 2-3.

4. Government of Scotland, (2005), Financial inclusion Action Plan|| , part of the Scottish executive's closing the Opportunity gap approach to tackling poverty.

5. Government of India, (2008) Report of the Committee on Financial Inclusion in India (Chairman Dr. C. Rangarajan), January.
6. Chant Link and Associates, (2004), A Report on Financial Exclusion in Australia, November, 2004.
7. H.M. Treasury, (2004), Promoting Financial Inclusion|| , HMSO, St Clements House, 2-16 Colegate, Norwich, December.
8. United Nations, (2006b), Building Inclusive Financial Sectors for Development|| , New York.
9. https://www.icrier.org.
10. http://www.soa.org.
11. http://ifmr.ac.in/cirm_011107/pdf/nrhmDoc.pdf
12. http://www.ifmr.ac.in/cirm/socsec-intro.htm
13. http://www.rbi.org.in/scripts/bs_viewcontent.aspx?Id=2234
14. http://rbidocs.rbi.org.in/rdocs/PublicationReport/Pdfs/65111.pdf

IJMRA