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The Third Wave of Microfinance: Health Inclusion

The first wave of microfinance began when Muhammad Yunus recognized that access to credit is a natural human right. In 1982, he founded the Grameen Bank in Bangladesh, and over the past three decades, he has relentlessly worked to make microloans to people living in poverty in underdeveloped countries. He believed that everyone is born as an entrepreneur and that financial inclusion will help alleviate poverty by allowing people to start small businesses. This approach has been copied and implemented all over the underdeveloped world. After lots of trial and error, Professor Yunus's microfinance model mainly focused on poor women because they lack rights and opportunities for empowerment. The second wave of microfinance has been its establishment over the past twenty years in highly developed countries, such as the United States and Europe. For example, five years ago, Yunus founded Grameen America to bring financial inclusion to impoverished people in this country, following the same principles. The third wave of microfinance is access to health care, and represents an important new opportunity since health inclusion is just as fundamental a human right as financial inclusion. People cannot be financially independent and build their small businesses if they are unhealthy and lack access to health care.

Focusing on health inclusion is a logical next step for microfinance because poverty and health outcomes are completely interrelated. As a result of Grameen Bank's loans to millions of Bangladeshi women, and many other Grameen joint ventures in education, food, water, shoes, and technology, maternal and child mortality rates have decreased substantially, even though the per capita GDP of Bangladesh is lower than that of India and Pakistan, which have much worse health outcomes. In both underdeveloped and developed countries, financial inclusion improves the health of impoverished people. In fact, access to health care and health insurance is critical for working people to support them in their jobs. The lack of health insurance jeopardizes people's financial stability, as medical bills are the leading cause of bankruptcy in the United States, and presumably in the underdeveloped world as well.

Two examples of microfinance institutions that address financial inclusion and health inclusion are BRAC and Pro Mujer. Based in Bangladesh and expanded into many developing countries, BRAC started to tackle health issues in 1991 and created its first health centers, called Shushasthyas, in 1995. Included in its mission, BRAC tries to achieve the Millennium Development Goals defined by the United Nations to improve health outcomes of ultra poor people using a door-to-door service delivery model and making primary care accessible. Similarly, Pro Mujer, which is based in Latin America, has extended its approach to financial inclusion to address health inclusion as well. Pro Mujer understands the detrimental impact of disease on women's ability to work if they or their

children get sick as a result of not receiving adequate medical care. Consequently, Pro Mujer provides preventive health education and primary care, and has set up clinics throughout the continent. It utilizes the basic principles of microfinance to have the participants meet every two weeks to discuss business challenges and health education. By linking access to financial and health resources, BRAC and Pro Mujer help poor women become independent, confident, and healthy leaders in their communities.

A new opportunity that is just being launched by Yunus in my community in New York City is Grameen PrimaCare (GPC). It is an offshoot of Grameen America and also seeks to provide health care and health education to underserved communities. The first clinic will be established in Jackson Heights, Queens, adjacent to the Grameen America branch. It will serve immigrants who are not covered by Obamacare and people in the informal economy, especially single mothers who do business with the Grameen America bank. GPC's mission is to provide access to health care, preventive services, and health education to this population. It will offer a different model of health care, including a capitated approach to reimbursement (using a global budget for a defined population) rather than a fee-for-service model. It will also enhance health literacy using peer support groups, "compañeros de salud" (health buddies), and innovative architecture in the waiting room to encourage communication. When I spoke with Pablo Farias and Diana Ramirez-Baron MD, the CEO and Medical Director of GPC respectively, they told me that the clinic will empower its patients, just like Grameen Bank does with its borrowers, to assume an active role in their treatment "with all the powers that they have" and to "mobilize that knowledge" about health rather than be passive recipients of care. GPC will be based on the very same principles of microfinance – to build from the ground up – that the lending institutions use, recognizing the importance of health inclusion in lifting people out of poverty. In my opinion, the third wave of microfinance is the focus on health inclusion as a critical component of achieving financial inclusion, and the new opportunity here in New York City is Grameen PrimaCare.