

‘More health for the money’: an analytical framework for access to health care through microfinance and savings groups

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Abstract The main contributors to inequities in health relates to widespread poverty. Health cannot be achieved without addressing the social determinants of health, and the answer does not lie in the health sector alone. One of the potential pathways to address vulnerabilities linked to poverty, social exclusion, and empowerment of women is aligning health programmes with empowerment interventions linked to access to capital through microfinance and self-help groups. This paper presents a framework to analyse combined health and financial interventions through microfinance programmes in reducing barriers to access health care. If properly designed and ethically managed such integrated programmes can provide more health for the money spent on health care.

Introduction

The main contributors to inequities in health relates to widespread poverty. About 1.29 billion people in developing world are living in extreme poverty, and are unable to lead healthy, productive lives because they are incapacitated by high rate of child mortality, maternal deaths, infectious, and non-communicable diseases (Chen and Ravallion, 2010). Disparities between poor and better off exist with respect to access to health care (Gwatkin, Wagstaff and Yazbeck, 2005). Social determinants of health such as poverty, inadequate housing and lack of education are at the root of morbidity in developing countries (Djukanovic and Mach, 1975). Good health cannot be achieved without addressing the social determinants of health, and the

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answer does not lie only in the health sector (Twiggs, 1999; Hunter, 2003; WHO, 2011; Tucker *et al.*, 2012).

Access to capital as an empowerment strategy for women has emerged as one of the options to address the effect of inequalities in power, prestige, income and wealth linked to different socioeconomic positions. The pioneering work of Prof. Muhammad Yunus in Bangladesh presented microfinance as a major tool to address poverty. Microfinance refers to provision of financial services such as loans, savings, and business training for the poor. There are wide varieties of microfinance models; the best known is the Grameen Bank model of group-based lending to the poor. In India, most of the microfinance-assisted entrepreneurs are organized as self-help group (SHG), with active support from the government. Members are mostly women, and are vulnerable to poor health conditions and financial shocks of illness. Routine group meetings are a forum to discuss not only financial activities, but also common problems affecting the community and family. This interaction and connectedness among members generates solidarity and social capital. Targeted health programme through these existing community level groups have the potential to reduce the unequal consequences of ill-health among a vast majority of the poor. Some of the benefits of integrating health services with microfinance include economic and social empowerment, and reduced gender disparity. This paper attempts to present and discuss a framework to analyse the role of those SHGs, organized around microfinance institutions (MFIs), with associated health programmes in reducing barriers to access health care.

Barriers to health services: social exclusion and marginalization

Multiple obstacles exist across the greater health system, including demand-side issues such as people's participation, knowledge, and behaviour. Krishna (Krishna, 2006) estimates the cost of treatment for illness to account for 85 percent of all causes of impoverishment in India. Poor health contributes to the persistence of India's high poverty rates, with health expenditures driving 39 million families into poverty each year (Selvaraj and Karan, 2009). In rural India, women are three times more likely than men to go without treatment for long-term ailments, a trend that persists even among the non-poor. Even when treatment is sought, significantly smaller sums of money are spent on medical treatment for women than for men (Iyer, Sen and George, 2007). Individuals with the greatest need for health care have the greatest difficulty in accessing health services and are least likely to have their health needs met (Balarajan, Selvaraj and Subramanian, 2011).

Access to health care has four dimensions: availability, geographic accessibility, affordability, and acceptability (O'Donnell, 2007). While traditionally health systems access barriers are classified as supply-side and demand-side barriers (Ensor and Cooper, 2004; Peters *et al.*, 2008), other important determinants of access include lack of female autonomy, lack of social support, social exclusion, and marginalization (Rutherford, Mulholland and Hill, 2010; Jacobs *et al.*, 2011). In Indian society where women are marginalised and have limited access to resources, these elements are likely to be of greater relevance (Adams, Madhavan and Simon, 2002). Social exclusion is a dynamic multi-dimensional process (Richardson and Le Grand, 2002; Doherty, 2003; Levitas *et al.*, 2007; Boon and Farnsworth, 2011) that produces barriers for those living in poverty. World Bank's work 'Voice of the Poor' argues that poor people lack a set of fundamental assets and capabilities. These capabilities include both distributional and relative issues, e.g. material assets, bodily health, bodily integrity, emotional integrity, respect and dignity, social belonging, cultural identity, imagination, information and education, organizational capacity and political representation and accountability (Narayan and Petesch, 2002). According to social exclusion theory, health risks are positively associated with involuntary social, economic, political, and cultural exclusion from society (Schurmann and Johnston, 2009). Research from Gambia suggests that strong social support networks are an important factor in health care access (Cassell *et al.*, 2006). These factors were more important than the traditional measures of access, where social support, not wealth, was a predictor of the care received by an ill child (Rutherford, Mulholland and Hill, 2010).

Microfinance and SHGs as a platform for health access

Microfinance has emerged from a development paradigm to alleviate poverty. However, poverty alleviation without addressing health will lead to a partial impact: poverty limits the capacity to produce health, and ill-health leads to further impoverishment (Wagstaff and Claeson, 2004). The nature of the microfinance transaction where (usually) women meet together in formal groups or SHG on a frequent basis to repay loans and deposit savings creates solidarity and social capital among members (Dunford, 2001). The groups hold meetings at regular interval, which last ~15–45 min, often in supervision of a credit officer, to save money, use their accumulated savings as a loans fund to help members repay loan when they are facing an emergency. A series of training meeting ensures financial discipline, record keeping of transactions, etc. These networks of savings and credit groups can influence health outcome through utilizing the financial and credit discipline, and creating social capital. Social capital (Putnam, 1993) is

feature of social organization, such as trust, norms, and networks that can improve the efficiency of society by facilitating coordinated actions. When women meet in the community group they discuss issues affecting their community and individual health, and exposure to health messages in such group meetings provides a critical pathway to influence health promotion (Viswanath, Steele and Finnegan, 2006), and increases the probability of being in good health (Rocco and Suhrcke). Woolcock (Woolcock, 1998) further splits social capital into three connecting strands: bonding social capital, i.e. ties between immediate family members, neighbours and close friends; bridging social capital, i.e. ties between people from different ethnic, geographical, and occupational backgrounds; and linking social capital, i.e. ties between poor people and those in positions of influence in formal organizations such as banks, schools, etc. Savings and credit groups such as microfinance are initiative mobilized by existing bonding social capital, and then built upon linking social capital as the group members get involved into activities (Kanak and Iguni, 2007).

Researchers argue that the peer pressure as disciplinary force in micro-credit, and relying on social collateral rather than material collateral, undermine trust and support. This increases the likelihood of poor and vulnerable groups being excluded from health care (Goetz and Gupta, 1996; Davis, 2001; Todd, 2005). Yet, an increasing body of primary research and review of evidence found participation in micro-credit and other women's group programme to be associated with positive health behaviour and outcome (Morduch and Haley, 2002; Leatherman and Dunford, 2010; Islam and Maitra, 2012; Leatherman *et al.*, 2012; Prost *et al.*, 2013). Schurmann and Johnston (Schurmann and Johnston, 2009) suggest four broad pathways in which micro-credit could have a positive impact: first, micro-credit serves as a medium to communicate health messages during regular repayment meetings. Second, micro-credit can improve the general quality of life of borrowers by increasing disposable income, reducing vulnerability through diversifying income sources, strengthening financial shock-coping mechanisms (insurance, savings), and building assets. Third, availability of credit can assist the poor with financing health emergencies, such as ill-health of the main breadwinner. The final pathway is building social capital through group meetings and mutual support.

Combining health and financial security for the poor

Unless vulnerabilities associated with health indicators outlined in the millennium development goals are addressed, public spending on health will continue to have a limited impact on population level outcome. Since much of the inequities in health result from a wide range of social, economic, and

political circumstances or factors that differentially affect the distribution of health within a population, the social determinants of health needs to be addressed (Balarajan, Selvaraj and Subramanian, 2011). Microfinance programmes and organizations promoting women's group emerged as a solution for access to capital for women and to address the effect of inequalities in power, prestige, income, and wealth linked to different socioeconomic positions. Aligning health programme with microfinance can address the 'double bottom line' of financial and social security for the poor. Such programme can leverage on the financial discipline and social capital generated out of members' participation in routine credit group meetings. The routine credit group meetings are an effective platform for delivering health message and information. In addition important interventions that can be combined include: loans for improved water source, home visits to counsel mothers on primary care including care of newborn, social marketing of family planning products and services, health insurance, loans and savings, and creating awareness about public health programmes and schemes.

NGOs like SEWA in India, BRAC and Grameen Bank in Bangladesh have extensively engaged in promoting health-related activities through participation of savings and credit group members. Such combined programme can take the form of

- (I) Programmes to address client awareness about preventive and promotive health care such as the programme to train women SHG members as health workers and to provide literacy training in the Comprehensive Rural Health Project, Jamkhed in Maharashtra state of India.
- (II) Programmes to address financing cost of treatment such as the mandatory pilot health-insurance programme of SKS Microfinance in India that offered cashless maternity, hospitalization and accident benefits among network hospitals to its members (Banerjee, Banerjee and Duflo, 2011). Another example of such a programme is the Velugu II project in Andhra Pradesh, India (renamed as Indira Kanti Patham) that sought to mitigate risk and improved security through a comprehensive insurance package covering health, life, crops, and livestock.
- (III) Programmes for access to healthcare products and services at doorstep such as community medicine points of Gram-Utthan, an MFI in Odisha state of India that makes a range of generic medicines and health supplies available in small villages; or other programmes that facilitate referrals of clients to diagnostic and screening services.

Globally integrating the delivery of health education with microfinance resulted in positive outcomes in reproductive health, prevention, and primary care for children: nutrition, breastfeeding and diarrhoea, HIV prevention, domestic abuse/gender-based violence, tuberculosis, and sexually transmitted infections. Health education alone, usually delivered during the routinely scheduled microfinance group meetings, improve knowledge that leads to positive health behavioural change (Leatherman and Dunford, 2010). Health programmes by microfinance institutions have positive impact on under-nutrition and diarrhoea, which are the most common causes of illness and childhood deaths in the developing world (Johnson and Rogaly, 1997; Marcus, Porter and Harper, 1999). A rare randomized control trial in the area demonstrated the impact of microfinance-based intervention on reduction of intimate partner violence in South Africa (Kim *et al.*, 2007). Evidence from Bangladesh showed credit recipients of BRAC pay more attention to health promotion activities in order to retain their eligibility to receive credit, free education for their children, and subsidized health care for their family members (Hadi, 2001).

A clustered randomized trial conducted assessed the impact of a community mobilization programme through participatory women's group among the indigenous communities of Jharkhand and Odisha states of India. Newborn babies born to mothers in SHG communities showed significantly improved likelihood of surviving the first 6 weeks of their lives, compared with babies born to analogous households in non-SHG communities (Tripathy *et al.*, 2010). A participatory approach to community mobilization through SHG in Maharashtra state of India resulted in a significant reduction in infant mortality, and birth rate. The initiative resulted in near universal antenatal care, safe delivery and immunization, and decline in malnutrition from 40 percent to <5 percent over the first 20 years of the programme (Arole and Arole, 2002; Rosato *et al.*, 2008).

Grameen Bank, the micro-credit pioneer in Bangladesh, provides its members with micro health insurance schemes in order to protect its clients from health risks with the aim of preventing their economic downfall. In 2006, a survey of members found insurance group placement contributes to increasing awareness of important health problems and to the probability of seeking formal care, compared with a control group (Hamid, Roberts and Mosley, 2011). In Andhra Pradesh state of India, women credit group members made significantly more use of health insurance than non-borrowing women who have obtained the insurance through their husbands (Rai and Ravi, 2011). A pilot project in Bangladesh integrating a micro-credit programme for poor women with an essential service package resulted in significant increase in contraceptive use, and a decline in fertility (Amin *et al.*, 2001).

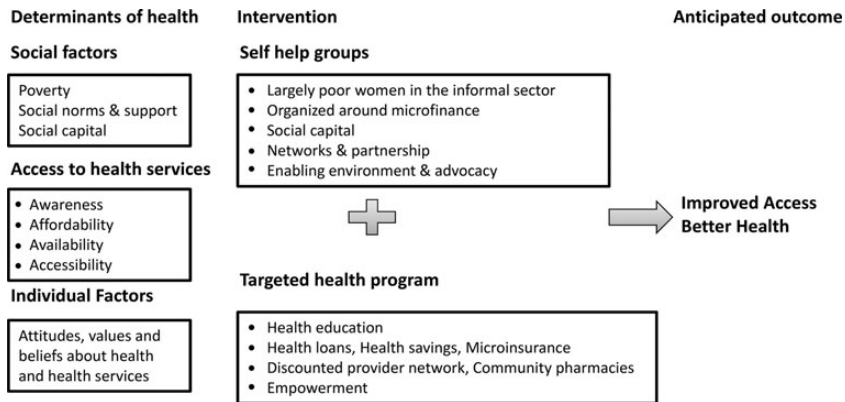


Figure 1 Framework for analysis.

A framework for analysing health outcomes

An integrated framework to address the social determinants of health by combining health with financial services is presented in Figure 1. This framework is intended to help analyse the effect of delivering health programme through SHGs and microfinance mechanism.

In analysing the impact of combining health with financial services, three main dimensions have been identified in the framework: determinants of health, structure, and operation of microfinance programmes, and form of health programme. A fourth overarching dimension relates to regulatory and policy environment.

Health has multiple determinants that include: social factors linked to poverty, social norms and support; access to health services which again is an interplay of availability, geographic accessibility, affordability, and acceptability (O'Donnell, 2007); and individual factors that governs people's knowledge, attitude, and beliefs about health and health services. An analysis of the context in which the programme operates is crucial in measuring programmatic impact.

The structure and operation of microfinance should consider history of the organization, its structure, and duration of participation. Joint liability model of microfinance that works on the principle of social cohesion as collateral for provision of the loans are instrumental in generating trust and social capital (Dunford, 2001; Szepter and Woolcock, 2004). The duration of participation in a microfinance programme matters in terms of the health and wellbeing of members (Mohindra, Haddad and Narayana, 2008). Organizations that are in operation for a relatively short term are less likely to detect slower-to-develop impacts such as on poverty and health (Leatherman *et al.*, 2012).

Programme to address members' health needs can be designed around demand-side access factors related to awareness and care seeking, as well as supply-side factors such as access to finance, consumption smoothing, and products. While health education is the most commonly reported intervention, other interventions include health camps, linkages to health providers, direct provision of services, health loans, health savings, and health micro-insurance (Metcalf, Leatherman and Gash, 2012). Along with type of services, the mechanism for delivery of health service needs to be analysed. An organization that has a deep rooted structure to ensure community participation mobilization and empowerment is more likely to succeed in addressing client health needs, than one that lacks such structure. Successful programmes like the Kakamega project in Western Kenya or the Jamkhed project in the state of Maharashtra in India had arisen from the process, and not from setting of performance targets or from external financing (Were, 2002; Rosato *et al.*, 2008). Hence a discussion on scalability of programme should delve on the structure, process and mechanism for delivery of health programme.

The starting point for this analysis is inadequate coverage among the poor due to a weak health system and imbalanced resource allocation. High level of illiteracy, lack of empowerment, and awareness among the poor and marginalized have left a gap that membership-based organizations like microfinance and SHGs can seek to address. Such organizations operate on a broader regulatory and policy environment that supports or hinders such initiative. Hence scalability of such integrated approach should also delve on the regulatory structure in which such schemes operate.

Discussion

Inequity in access to health care is a key barrier to achieve the Universal Health Coverage (UHC) vision of the 65th World Health Assembly. Work of the Commission on Social Determinants of Health emphasized the role of civil society in promoting health equity (Gilson *et al.*, 2007). Community system strengthening and community mobilization are crucial for ensuring that UHC works equally for the general population as well as for poor and marginalized groups (Ravenscroft and Marcos, 2012). Financial service providers of all types (MFIs, SHGs, or other NGOs providing financial services to the poor) represent a viable, sustainable channel for reaching the poor: In India, 93 million clients – are involved in microfinance activities offered by MFIs and SHG-Bank Linkage programme, such as Self-Health Group Federations. They were actively promoted by various national and state programmes for financial inclusion and livelihood promotion among rural population particularly women. Increasingly, the financial services sector is

exploring the addition of other non-financial services critical to the well-being of the poor, most notably, the delivery of simple but life-saving health services. MFIs and SHGs not only have compelling business reasons to attend to their clients' health needs, they are often uniquely positioned in the communities they serve as trusted intermediaries between community members and the outside world. A growing body of evidence from around the world indicates that when health and financial services for the poor are linked in a systematic and cohesive manner, key barriers to health for the poor can be reduced.

In this paper, we have discussed a framework to analyse the effect of access to health care through community-based SHGs and microfinance programmes. The micro-financing model can simultaneously promote access to quality maternal health services, better reproductive and child-health awareness, and ultimately integrate SHGs into formal community health programmes and policy development structures. If properly designed and ethically managed, such groups can provide more health for the money spent on health-care. Yet questions and concerns remain, particularly related to financing the start-up capital, absorbing cost of the development interventions, models for convergence, and capacity to deliver health programme. Governments have a constructive role in building systems that work for the poor. The role of the state encompasses insuring a minimum banking structure in the rural areas, subsidizing microfinance start-up capital and innovations, and investing in complementary services such as infrastructure, health, and education (Lapenu, 2000). Such structure should play an effective role in ensuring people's participation in health system as an agent that actively shapes the system and how services are financed and delivered. This calls for increased focus on training and capacity building of these organizations in terms of leadership skills and strengthen accountability and participation. The focus should be on building sustainable institutions, rather than projects. Yet, such programmes cannot be viewed as a panacea for government failures, but rather a complement to public provisioning of health services (Leatherman *et al.*, 2014). Also rigorous evaluations that not only look into programme impact, but also intervention factors and studying scalability of successful models are the need of the hour. Wider replication of these programmes requires large-scale effectiveness studies with active support and involvement of public health policy planners and donors.

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