

# Improving Access to Health Care Services through Community Risk Pooling in Agra

International Conference on Urban Health  
29-31 October, 2008

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## Outline of presentation

- Avoidable deaths
- Burden of healthcare on the poor
  - Costs of treatment: Indirect and direct
  - Sources of funds
  - Who do government subsidies benefit
  - Economic burden of hospitalization on the poorest
- Program experiences
  - How can community groups address these challenges
- Challenges and Program Implications

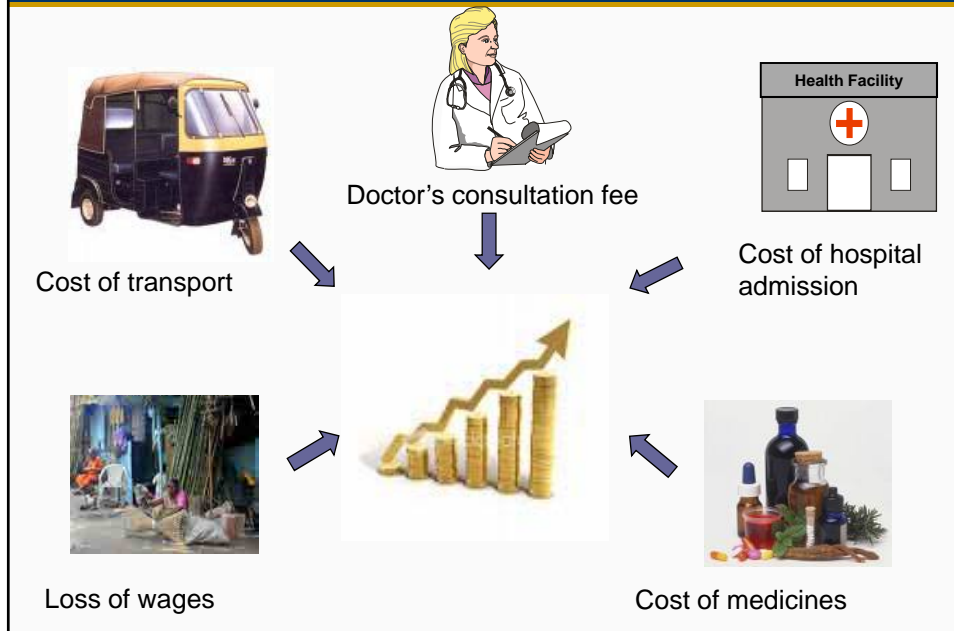
## Avoidable deaths in India

- Millennium Development Goals 4 and 5 target to reduce maternal mortality by 75 per cent and child mortality by 66 per cent from the levels seen in 2000.
- In India, an estimated 136000 mothers and 2.5 million children die every year, most often due to causes that are preventable or easily treatable if immediate help is available.
- India should reduce its Maternal Mortality Ratio (MMR) from 540 to 135, and its under-five child mortality from 96 to 32 to achieve MDGs
- Repeated illnesses reduce an individual's productivity; such individuals are a drain on the nation's economy

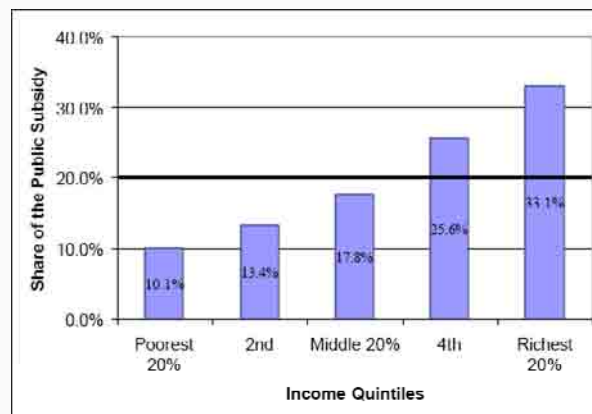
## Burden of healthcare on the poor

- Households undertake nearly three-fourths of all the health spending in the country (National Commission on Macroeconomics and Health, 2005)
- For urban households, spending on health accounts for 5.2 per cent of their total consumption expenditure up from 4.6 per cent in 2003-04 (National Sample Survey data for 2004-05)
- Household health care expenditure imposes a heavier burden on the poor.
- For them it has emerged as the largest source of indebtedness than on the well to do.

## Cost of treatment: Direct and Indirect



## 78% Public subsidy for Curative Care Goes to Richest 3 Quintiles



Ajay Mahal et al, 2001

## Forced to borrow from money lenders



Erratic income



No savings



No support from banks



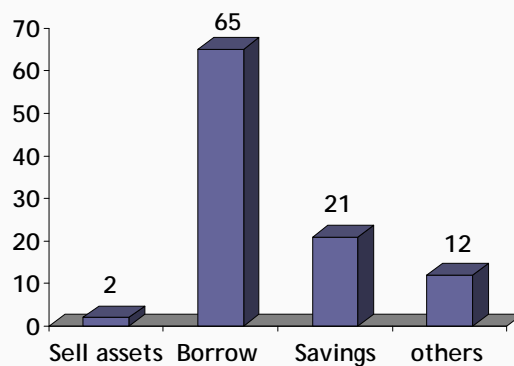
No social support;  
as most are  
nuclear families



Forced to borrow from local money lenders at high rates of interest

A study of Nagpur city by the National Institute of Urban Affairs (2001) recorded that 14.4% of slum households incurred debt on account of illness

## Economic Burden of Hospitalization on Poorest Quintile



Gumber and Berman, 1994 using NSS 1995-96

## Program Experiences

### Addressing the problem in Agra



- Active and socially committed women emerged from program slums and were organized into groups
- Capacity of these groups was built through training sessions with help of local NGOs
- Provided inputs to build institutional, program (providing knowledge on healthcare), linkages and financial capacity
- There are 96 such groups in Agra

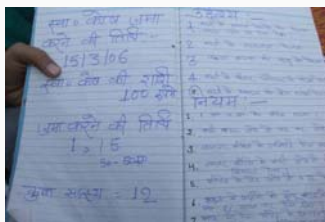
## Promoting health funds



Women in slums realizing the importance of ready source of money, started health funds



Women contribute Rs.10 to100, monthly to the health fund



Rules, regulations and all financial transactions are documented



Groups are being encouraged to have bank accounts

## Initiation

- After the groups have developed a deep understanding of their objective of improving health of their fellow basti residents and have been undertaking related activities successfully, they are stimulated to initiate health funds
- Groups stimulated through the following processes
  - Helping the group identify examples where a family has experienced lack of money for treatment
  - Organizing cross visits to groups who have a fund
- After group members are convinced of the need, they initiate collective saving
- Groups are then helped to develop rules and regulations after a thorough discussion among all members

## Maintenance of records and bank account

### Maintenance of records

- Capacity building sessions on documentation organized
- Literate members are encouraged to take the lead
- Treasurer appointed to take care of financial transactions
- Encouraged to ensure transparency in financial dealings

### Bank accounts

- Once the group has sufficient money and has been undertaking financial dealings successfully for sometime, they are introduced to the idea of a bank account
- Account is in the name of the group and has three elected signatories

## Rules and regulations

- Monthly contribution: Decided depending on paying capacity of the financially weakest member. Some groups have also increased their monthly contribution overtime depending on needs
- Loan Disbursal
  - ▶ Prioritization facilitated; health given highest priority
  - ▶ Deadlines fixed to return money
  - ▶ Fines in event of delays
  - ▶ Application for seeking loans; provision and format
  - ▶ Emergency Loans; minimum members (usually 3) required to decide disbursal of loan during emergencies when all members cannot be immediately informed
  - ▶ 1-2 guarantors-A prerequisite
- Interest rates: Generally lower for group members than for non-members, and for health loans

## Outcomes: Agra

*Total amount collected and sources [as of Feb 2008]*

Contribution by members	Donations	Renting of sitting mats and dholak	Interest on loans	Fine or penalty	Other sources	Total
347103	9500	21874	59237	356	2000	384167

*Creative ways to increase health fund, besides monthly contribution and interest*

- ❑ Renting out dholaks or sitting mats in times of weddings or other ceremonies that occur in the basti (slum). Rent varies from Rs.20 to Rs.50.
- ❑ Purchasing utensils and tents from their fund money and renting them out at rates lower than what the basti residents may get in the market.
- ❑ Organizing prayer ceremonies and using offerings as donations to the fund.

## Outcomes: Agra

- In Agra 84 groups, representing 140,000 slum population, have collected Rs.384167 between February 2006 and February 2008
- 37 of these groups have a bank account
- Groups have given out 333 health loans amounting to 240500
- Other loans were for education housing, marriage etc.
- Groups have generated Rs.59237 as interest which ranges between 2% to 5%.
- Repayment is around 95%.

## Challenges and Program Implications

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### Challenges

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- Hesitation and refusal by some members to contribute money to the health fund owing to:
  - Perception that the health fund is equivalent to saving money at home
  - Extreme poverty
  - Fear of pilferage by NGO staff or other members
- Difference of opinion among group members due to social factors
- Deviation of focus from health activities to increasing money in the health fund and thinking of livelihood options at a premature stage
- Poor documentation due to most women being illiterate
- Weak and incomplete rules causing conflicts

## Implications

- Improved access to health care
  - Ready money at slum level for meeting health exigencies
  - Unnecessary delays in seeking treatment avoided; more mothers, children saved from infirmity and death
- Reduction in financial burden
  - Loan available at lower interest than money lenders
  - Indirect cost reduced as women have right knowledge and the ability to negotiate for better health care services
  - Freedom from exploitation by local money lenders

## Implications

- Empowered, happier, more confident women
  - Increased decision making capacity among women
  - Increased confidence and ability to handle money
  - Increased knowledge of accounting
  - Increased access to banks and other external stakeholders
- These organized groups also provide an impetus to the public healthcare delivery system by increasing demand
- Possible linkage to insurance schemes
- The approach has been incorporated as an important strategy in the National Urban Health Mission of India which aims at addressing the health concerns of the urban poor in the country.



*Imagination is the beginning of creation. You  
imagine what you desire, you will what you imagine  
and at last you create what you will.*

-George Bernard Shaw