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窮人銀行開醫院的角色衝突：孟加拉經驗探索

When creditor and health provider collide: exploring
microfinance-based hospitals in Bangladesh

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本論文係曾育慈君 (F95845108) 在國立臺灣大學健康
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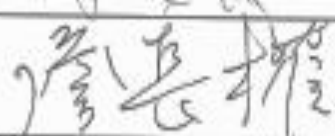

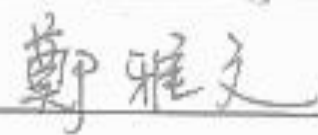

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Table of Contents



Acknowledgement.....	i
Acronyms.....	ii
Abstract	iii
摘要.....	vii
List of Tables and Figures	ix
Chapter 1 Introduction.....	1
1.1 Background	1
1.2 Rational of the study	5
Chapter 2 Literature review.....	6
2.1 Microcredit and its current state	6
2.2 Microcredit and health	11
2.3 Microcredit and inequality	14
2.4 Context of study	16
2.5 Conceptual framework	27
Chapter 3 Questionnaire Survey.....	30
3.1 Study objectives	30
3.2 Methods and materials	30
3.3 Results	38
Chapter 4 Qualitative study	44
4.1 Study objectives	44
4.2 Methods and materials	44
4.3 Results	49
Chapter 5 Discussion.....	91
5.1 How was target population missed?	93
5.2 Why was target population missed?	96
5.3 Credit and health care – an unequal linkage	101
5.4 Governance and accountability	105
5.5 Community clinics, how do MFIs cope?	108
5.6 Limitation	110
Chapter 6 Conclusion	112
Reference	114
Annex: Questionnaire	124

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This publication is dedicated to my parents.

謹以此文獻給我最愛的父母親。

Acronyms




AL	Awami League
ANC	Antenatal Care
BNP	Bangladesh Nationalist Party
CHCP	Community Healthcare Provider
GDP	Gross Domestic Product
GOB	Government of Bangladesh
MFI	Microfinance Institution
MOHFW	Ministry of Health and Family Welfare
MRA	Microcredit Regulatory Authority
NGO	Non-Governmental Organization
PKSF	Palli Karma-Sahayak Foundation (Rural Employment Support Foundation)
PO	Partner Organization
TBA	Traditional Birth Attendant
THE	Total health expenditure

Abstract



Introduction: Health programs implemented by microfinance institutions (MFIs) aim to benefit the poor, but whether these services reach the poorest remains uncertain. This study intended to investigate the patient profiles and policies in the hospitals operated by microfinance institutions (MFI hospitals) in Bangladesh and make a comparison with public hospitals to determine if such initiatives were consistent with their pro-poor mandate. This research came in two parts. The first part paid attention to patients. A survey was conducted to examine patients' hospital utilization by predisposing, enabling and need determinants. The second part focused on hospitals. It took advantage of qualitative approach to probe into the service delivery, manpower, financing and other aspects of the health care system through in-depth interviews and observation. Drawing on the evidence derived from stakeholders such as providers, users, policy makers and practitioners, implications of MFI hospital-based programs were discussed.

Methods: In this cross-sectional study, the author used the convenience sampling method to administer an interviewer-assisted questionnaire survey among 347 female outpatients, with 177 in MFI hospitals and 170 in public hospitals. Independent variables were patient characteristics categorized into predisposing factors (age, education, marital status, family size), enabling factors (microcredit membership, household income) and need factors (self-rated health, perceived needs for care). The statistical method of Generalized Estimating Equations (GEE) was



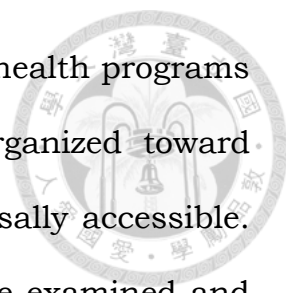
employed to evaluate how these factors contributed to MFI hospital use. In the qualitative approach, details on the provision of hospital care in the public and MFI sectors were collected among 27 stakeholders, including microcredit practitioners and borrowers, MFI hospital managers, MFI regulatory bodies, care providers, academics, and health officials at central and local levels. Respondents were recruited by using purposive sampling to ensure inclusion of critical cases from two types of care. Other data sources included researchers' observation, field notes and publications provided by interviewees. Data were analyzed using framework analysis which established steps to deal with data according to key issues and themes. Key themes included service delivery, resources, provider behavior, manpower, utilization, affordability and implications. Finally, results from the interviews were combined with findings from the quantitative study before drawing conclusions.

Results: Use of MFI hospitals was significantly associated with microcredit membership over 5 years (OR=2.9, $p<.01$), moderately poor household (OR=4.09, $p<.001$), non-poor household (OR=7.34, $p<.01$) and need for preventive care (OR=3.4, $p<.01$), compared with public hospitals. Microcredit members had a higher tendency towards utilization but membership effect pertained to the non- and moderately-poor. Compared with the patients who were non-members and the poorest, microcredit members who were non-poor had the highest likelihood (OR=7.46, $p<.001$) to visit MFI hospitals, followed by members with moderate income (OR=6.91, $p<.001$) and then non-members in non-poor

households (OR=4.48, $p < .01$). Those who were members but the poorest had a negative association (OR=0.42), though not significant. Despite a higher utilization of preventive services in MFI hospitals, expenditure there was significantly higher.

Qualitative probe found that, although public hospitals provided universal and low-cost care, the public sector suffered from insufficient workforce and infrastructure. In MFI hospitals charges were slightly cheaper than private clinics but much costlier than their public counterparts. To contain cost, MFI hospitals had highly flexible manpower arrangements. To generate income, MFI hospitals adopted proactive strategies to solicit desired patients. They not only selected patients through the pricing schedule but avoided complicated cases and left the poor patients to the public sector. Interviews also revealed that MFIs and government officers had divergent interpretations regarding complementarity and social responsibilities. While government officers expected collaboration at the field level and in prevention, MFIs opted for client segmentation. Finally, governing authorities were inconclusive about commercialization of MFI health programs.

Conclusion: Inequity was more pronounced in MFI hospitals than public ones. By detaching themselves from the poor, the claims to serve the poor became rhetoric. The government, in addition to facilitating growth of MFIs, it seemed to take a laissez-faire policy with regards to MFIs' hospital venture. Thus, using microcredit as a platform to deliver public goods or strengthen health system might not be a good idea without



explicit policy guidance. The researcher suggested that health programs of MFIs be separated from the credit wing and reorganized toward primary health care to make care equitable and universally accessible. Hospital initiatives in the microfinance sector should be examined and regulated by both the health and microcredit regulatory authorities. This study holds practical implications for governments, development agencies and microfinance practitioners.

Keywords: microcredit, microfinance institution, Bangladesh, hospital care utilization; health inequality, poverty alleviation

摘要

前言：微額貸款機構（微貸機構）提供的醫療服務宣稱照顧窮人，但受惠者是否包含最貧窮的人群，目前尚屬未知。本研究以孟加拉為田野，調查微貸機構設立的醫院（微貸醫院）中病人社經處境與醫院運作情形，並與公立醫院做比較，藉此了解微貸機構經營醫院的策略是否與其宣稱的友善窮人宗旨一致。本研究包含兩部份。第一部份針對病人，在門診向候診病人進行問卷調查，蒐集影響醫院醫療服務利用的前傾、使能與需求三類決定因子；第二部份針對醫院，採用質性研究方法，依據健康體系重要面向，包括服務提供、人力、財務等，透過深入訪談與參與式觀察的方式做資料蒐集。研究者將分析來自所有利害相關人，從照護提供者、使用者、決策者到微貸工作人員的資料，呈現微貸機構參與健康部門的現況並討論政策意涵。

方法：本研究為橫斷研究。第一部份由訪員在醫院採便利取樣，向女性門診病人進行問卷調查，有效樣本共 347 份，分別來自微貸醫院 177 名與公立醫院 170 名。蒐集的自變項資料包括年齡、教育、婚姻狀況、家庭人口數、是否參與微貸以及參與時間、家戶所得、自評健康與自覺需求。依變項為是否使用微貸醫院。統計分析使用卡方檢定與廣義估計方程式（Generalized Estimating Equations）。質性研究的訪談對象有微貸機構高階經理人、病人、公立醫院與微貸醫院的管理階層與照護提供者、中央與地方衛生官員與學者共 27 名。為確保兩種類型的利益相關者均能納入，受訪者由立意取樣方式產生。其它資源來源亦包括研究者的參與式觀察、田野筆記和微貸機構出版品。質性資料的分析採用架構分析法（framework analysis），依據服務提供、資源、提供者的行為模式、人力、利用情況、可近性等關鍵主題做資料的歸納與分析。最後，研究者整合可彼此呼應的質量性結果，提出結論。

結果：與公立醫院相比，微貸醫院的利用與下列因素有顯著相關，包括加入微貸機構會員達五年以上(OR=2.9, $p<.01$)、中等貧窮家戶(OR=4.09, $p<.001$)、非貧窮家戶(OR=7.34, $p<.01$)，以及預防性健康服務的需求(OR=3.4, $p<.01$)。微貸會員使用微貸醫院的機率較高，但此效果僅限於來自非貧窮與中等貧窮家戶的病人。若同時從經濟地位與是否為微貸客戶兩個面向觀之，不貧窮的微貸客戶、中

等貧窮的微貸客戶、不貧窮的非微貸客戶使用微貸醫院的機率，分別是最窮的非微貸客戶的 7.46、6.91 與 4.48 倍。然而，雖然統計上不顯著，但最貧窮的微貸客戶與微貸醫院的利用關係呈現負向。此外，病人在微貸醫院使用的項目多半為預防性服務，醫療費用卻顯著較高。

質性調查發現公立醫院提供全面性且價格低廉的照護，但包括人力在內的現有軟硬體依然不足以因應。在醫療費用方面，微貸醫院收費僅比私人診所稍低，卻比公立醫院高出數倍至百倍不等；在人力方面，微貸醫院採用彈性雇用策略以節省人事成本；在財源方面，微貸醫院同時透過定價和選擇輕症病人來提高收入，而為增加病人量，微貸機構亦支付佣金鼓勵社區服務人員來招攬病人或推銷套裝服務。關於微貸機構的社會責任，以及公部門與微貸部門的合作內涵，前者期待微貸做為非政府組織，應投入基層的衛生保健，然後後者卻主張不同社經階層病人的分流。對於微貸醫院的商業化走向，主管機關的意見出現明顯的分歧。

結論：與公立醫院相比，微貸醫院存在明顯的使用不平等，顯然與其宣稱的宗旨不符。政府從一開始扶持微貸機構，之後對於微貸機構涉入醫院經營亦採取自由放任的態度似乎助長此風。本文作者認為，在缺乏立場明確的政策引導和規範之下，以微貸做為平台來提供公共服務或期待微貸結合醫療能夠強化健康體系，可能無法達到除貧或提昇人群健康福祉的目標。建議微貸機構的健康方案與微貸業務分開，並調整健康計畫的方向，以提供普及且公平的基層保健服務為主軸。其次，建議政府的微貸與健康主管機關針對微貸機構經營之醫療院所加以定位，納入監督與規範。本研究提供的實證資料，對於政府部門、微貸機構與發展援助組織具有政策參考價值。

關鍵字：微額貸款、微貸機構、孟加拉、醫院醫療服務利用、健康不平等、除貧

List of Tables and Figures



Table 1. Regional Breakdown of Microfinance in 2010.....	9
Table 2. Bangladesh at a glance.....	17
Table 3. Comparative health indicators across the region	19
Table 4. Composition of MFI sources of fund 2009-2013.....	23
Table 5. Site and hospital characteristics	33
Table 6. Patient characteristics and cost of care in MFI and public hospitals	40
Table 7. Adjusted odds ratios (and 95% confidence intervals) of factors associated with MFI-hospital utilization.....	42
Table 8. Adjusted odds ratios of combined factors to predict MFI hospital use	43
Table 9. Categories and positions of participants.....	50
Figure 1. Regional Breakdown of Access to Microfinance.....	9
Figure 2. Upward trend of research articles on microfinance - search results from ScienceDirect and PubMed since 1990s.....	10
Figure 3. Map of Bangladesh.....	16
Figure 4. Trends in under-5 and infant mortality, 1985-2013	19
Figure 5. Growth of PKSf's partner organizations, 1991-2014.....	21
Figure 6. National coverage of PKSf	21
Figure 7. National and global context of NGO-MFI development	24
Figure 8. Health Care Management and Delivery Hierarchy	26
Figure 9. Distribution of outdoor patients and admissions by type of facility, 2013.....	26
Figure 10. Conceptual framework.....	27
Figure 11. Analytical framework for microfinance-based health care system	45
Figure 12. Fees for caesarean section by provider and district	67
Figure 13. An illustration of microfinance-based health care system....	92

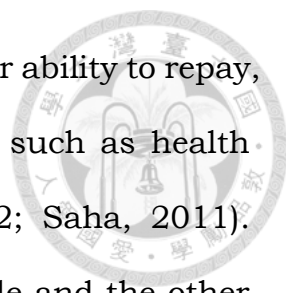
Chapter 1 Introduction



1.1 Background

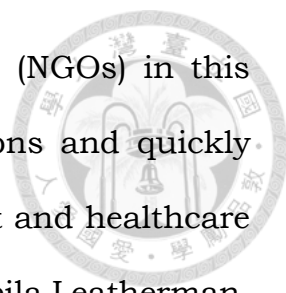
The sick among the poorest are the world's most vulnerable people. The need to remove barriers to access healthcare is urgent, particularly in low-income countries (UN, 2013; WHO, 2001). While there have been attempted interventions to increase availability and accessibility to health services and products, socioeconomic differentials of the utilization have not been addressed, and the poorest segment of the population often benefitted the least (Ahmed & Zerihun, 2010; Amin, Shah, & Becker, 2010; A. Anwar, Killewo, Chowdhury, & Dasgupta, 2004; I. Anwar et al., 2008; Chowdhury et al., 2006; Hossain et al., 2012; Quayyum et al., 2013). As a result, the destitute delayed seeking health care due to their low capacity to pay (Killewo, Anwar, Bashir, Yunus, & Chakraborty, 2006; Rutebemberwa, Kallander, Tomson, Peterson, & Pariyo, 2009), which might eventually lead to catastrophic health spending (Xu et al., 2003). It indicated that using an equity lens in the evaluation of program design and targeting is crucial.

Working with the poorest of the poor to improve their welfare has been the professed goal of microfinance institutions (MFIs) (Maes & Reed, 2012; Yunus & Jolis, 1998). Initially, microcredit practitioners introduced health programs when they identified unmet needs of the poor due to a lack of access and inability to afford care (Sheila Leatherman, Saha, Gash, & Metcalfe, 2010). On the other hand,



non-financial programs rewarded MFIs with clients' better ability to repay, increased client loyalty and a new income opportunity such as health financing and charging user-fees (Maes & Reed, 2012; Saha, 2011). These two types of motivation, one from the demand side and the other from the supply side, may have a potential conflict and therefore deserve scrutiny. While microcredit presents an opportunity for the poor to engage in income-generating activities, by nature it is a profitable business, with higher interest rate (12-40%) and high repayment rate (near 100%). On the other hand, if health care is to be made affordable for the poor, the provider must charge low or nil user fees. In this case, financing has to be supported by other means. How do MFIs maneuver between the two types of work with two different philosophies? This is where a potential collision might occur. Thus, it is important to ask what pro-poor measures MFIs take in their health programs and whether these services reach MFIs' target population. Since MFIs uphold the signboard of reaching the poor and the poorest, decomposing data by socioeconomic strata is the first step to answer the question.

The impact of MFIs is profound, given the huge number of people exposed to their activities. Among the 3,718 MFIs that have reported to the Microcredit Summit Campaign since 1998, 1,747 (46.99%) were based in Asia and the Pacific, and heavily concentrated in India and Bangladesh. MFIs in these two countries have reached 102 million of the poorest, of which 11.46% reside in Bangladesh, the birthplace of institutionalized microcredit programs (Reed LR, Marsden J, Ortega A,



Rivera C, & S, 2014). Non-governmental organizations (NGOs) in this country have had a rich heritage of health interventions and quickly introduced integrated projects by combining microcredit and healthcare (Amin, St Pierre, Ahmed, & Haq, 2001; Haque, 2004; Sheila Leatherman, Metcalfe, Geissler, & Dunford, 2011; Zohir, 2004). As NGO-MFIs grow larger in volume and size, some have moved beyond the realm of primary health care and started running hospitals.

Running general hospitals is a relatively new phenomenon in the evolution of MFI, and therefore evaluation of the utilization of such hospitals is scarce. Previous studies only pointed out a positive association between microcredit membership and utilization of health services (Amin et al., 2010; Amin et al., 2001; Nanda, 1999). Community-based programs using outreach health workers appeared to have a positive effect on equity (Quayyum et al., 2013). However, while MFIs' primary health care programs have produced encouraging results (Mercer, Khan, Daulatuzzaman, & Reid, 2004), little is known about their hospital services.

Besides the MFIs, the public sector is also working in the same direction to ensure indiscriminate access for the most vulnerable (Andrulis, Acuff, Weiss, & Anderson, 1996; Stanton & Clemens, 1989). Single country and multi-country research suggested a higher likelihood of the poorest seeking care from public providers (Saksena, Xu, Elovainio, & Perrot, 2012; Sohail, 2005). In this study, the author concurrently investigated characteristics in MFI and public hospitals in the aspects of

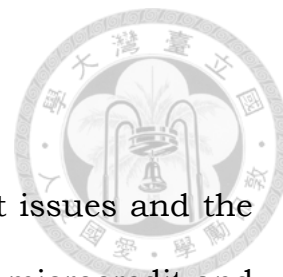
patient profile and key components of their structure such as service delivery, manpower, financing, governance, etc. By comparing and analysing the practice in two settings, this research presented the extent to which MFI hospitals served the poorest and its implications.

Utilization of health services is influenced by characteristics of population at risk and characteristics of the delivery system, established in the Behavioural Model of Health Services Use (Aday & Andersen, 1974; Andersen, 1995). Guided by this approach, the researcher undertook two studies with one focused on the patients and the other on the microfinance-based delivery system.

1.2 Rational of the study

It is well documented that unequal access to care contributes to health inequalities (Friel et al., 2011). Also a commonly held notion is that government and non-governmental actors in developing countries can be complementary in the health care delivery system (Dina Balabanova et al., 2013; El Arifeen et al., 2013; Streefland & Chowdhury, 1990; Ullah, Newell, Ahmed, Hyder, & Islam, 2006; Zohir, 2004). Bangladesh has witnessed a slow but steady growth of NGO-MFIs engaging in hospital operation. How does this phenomenon contribute, or whether it does contribute, to strengthen the complementarily working relationship? Whether this strategy has been aligned with government policy and narrowed the equity gap requires ongoing monitoring and systematic evaluation. Will such integration help correct government and market failures envisioned by public health professionals (Asif. Dowla, 2006; Durairaj, Sinha, Evans, & Carrin, 2010; Sheila Leatherman et al., 2011)? To address these issues, this paper is the first attempt to add the missing piece to the knowledge base. As debate about microcredit continues, findings from this research could enrich the current discussion. Understanding the impact can be translated into evidence-informed policies of government bodies that regulate MFIs, development agencies that fund or promote health programs of MFIs, and large MFIs that are considering to open hospitals or planning on poor-friendly initiatives.

Chapter 2 Literature review



This chapter provides a literature review of relevant issues and the study field. Section 2.1 briefly introduces the concept of microcredit and its current state. Sections 2.2 and 2.3 reviews existing work on the relation between microcredit, health and inequality. Section 2.4 describes the context of Bangladesh, its general information and microfinance in this country. Last, the conceptual framework is illustrated in section 2.5.

2.1 Microcredit and its current state

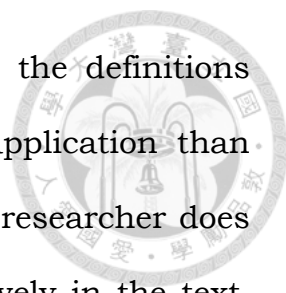
Microcredit and microfinance are two terms alternatively used to refer to financial services to the poor. Consultative Group to Assist the Poor (CGAP) – a global partnership of 34 official development aid agencies and intergovernmental organizations – defines microcredit and microfinance as:¹

“Microcredit refers to very small loans for unsalaried borrowers with little or no collateral, provided by legally registered institutions.”

“Microfinance typically refers to a range of financial services including credit, savings, insurance, money transfers, and other financial products provided by different service providers, targeted at poor and low-income people.”

Organizations providing microcredit-related services are generally

¹ <http://www.microfinancegateway.org/p/site/m/template.rc/1.26.12263/>



called microfinance institutions or MFIs. According to the definitions listed above, microfinance appears to have a wider application than microcredit. The latter covers the former. However, the researcher does not intend to differentiate and may use them alternatively in the text. Some researchers prefer to use microcredit over microfinance, such as Mohindra & Haddad (Mohindra & Haddad, 2005; Mohindra, Haddad, & Narayana, 2008) who consistently use this term in their works. In Bangladesh, microcredit is the officially accepted term. Bangladesh Bank established Microcredit Regulatory Authority (MRA) in 2006 to regulate all activities of MFIs. During the past trips to Bangladesh during the 2000s, the researcher noticed that Bangladeshis tended to use microcredit in almost all occasions. These instances show that these two terms are exchangeable. Because this research focused on Bangladesh and targeted Bangladeshi audience, “microcredit” would be used in most cases while “microfinance” would be referred to when citing other scholars or publications that used microfinance.

2.1.1 Features of Microcredit

Microcredit is characterized by collateral-free, small amount of money loaned to an individual or group by a bank or MFIs. Money was to be invested in income generating activities, usually in the informal sector. It was not until the success of Grameen Bank in Bangladesh in the 1980s did the world start to pay serious attention to microcredit. Since then, the process of formalizing this financial service to the poor began (Brau &

Woller, 2004).

Microcredit, unlike traditional banking, takes an outreach approach. It usually takes place in rural area, among poor population which conventional banks regard “unbankable”. Instead of sitting in the office for clients to apply, loan officers go to the field to disburse loans and collect repayment in the open on a weekly basis. The group-based lending has facilitated a couple of positive changes on the side of borrowers including solidarity among group members, frequent communication with the community, and information exchange (Yunus & Jolis, 1998). To ensure recovery in the absence of tangible guarantee, MFIs have created a mechanism to create joint liability or peer monitoring (Karim, 2011; Mohindra & Haddad, 2005).

2.1.2 Current state of microcredit

Microcredit received international spotlight when the first Microcredit Summit was held in 1997 in Washington, D.C., the capital of the United States. At the summit the US-based Microcredit Summit Campaign started a 9-year program to reach 100 million of the world’s poorest families (Yunus & Jolis, 1998).

The United Nations made 2005 “International Year of Microcredit” to promote it as a tool toward development that entailed poverty alleviation, access to resources and women’s decision-making power. The microcredit campaign picked up momentum after the 2006 Nobel Peace Prize given to Yunus and his Grameen Bank (Dossey, 2007; Malik, 2008).

Results of international campaign by UN and its specialized agencies such as UN Development Program (Watkins, 2006), development organizations, donors, some governments and NGOs were reflected in the increasing prevalence of microcredit schemes in most part of the developing world (table 1), with people in Asia having the highest access when comparing with data on people living on \$1.25 a day (figure 1).

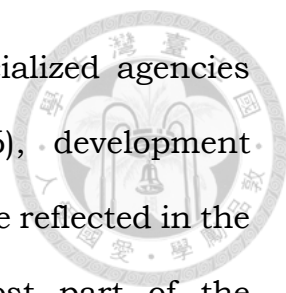
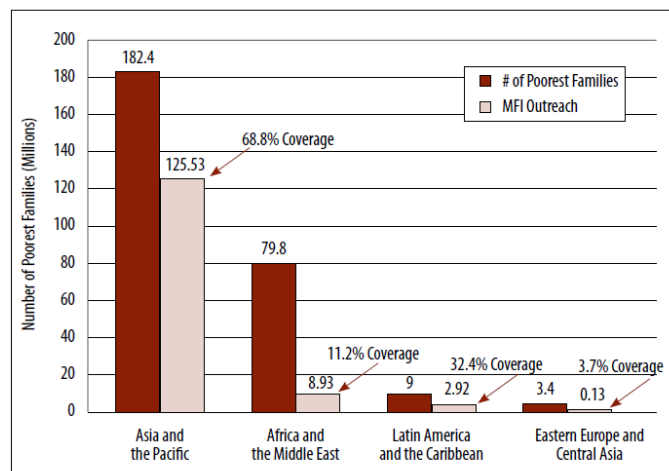


Table 1. Regional Breakdown of Microfinance in 2010

Region	Total Clients	Poorest women clients
Asia & the Pacific	169,125,878	104,752,430
Latin America & the Caribbean	13,847,987	2,363,100
Sub-Saharan Africa	12,692,579	4,783,256
Middle East & North Africa	4,290,735	1,165,358
Developing World Totals	199,975,179	113,064,144

Source: Maes and Reed, 2012

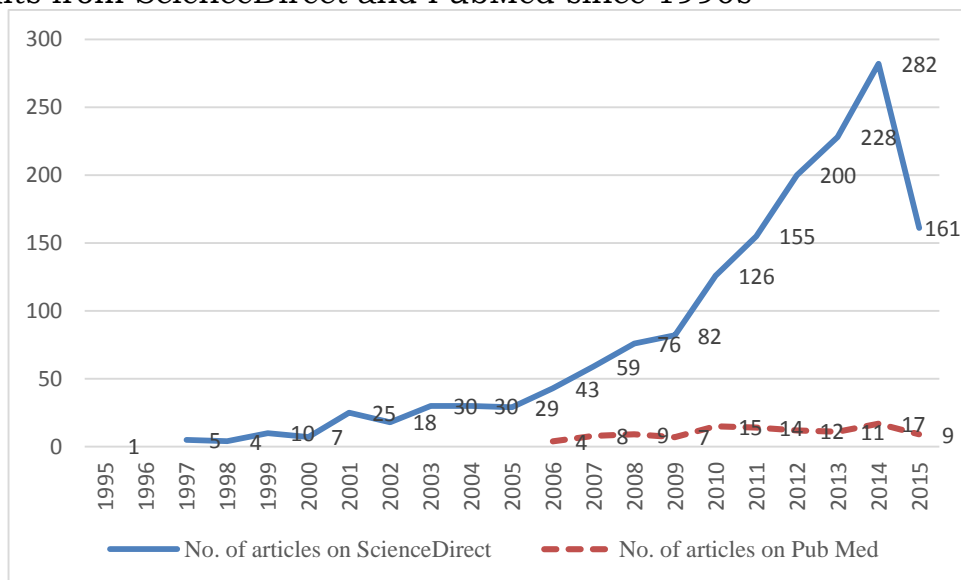
Figure 1. Regional Breakdown of Access to Microfinance



Source: Maes and Reed, 2012

Extensive visibility created by the campaign probably explained the spark of academic interest from the late 1990s. As a result of vigorous promotion, the number of published articles on microcredit or microfinance sharply increased. Figure 2 shows an upward trend of articles indexed in two major databases up to the first quarter of 2015, indicating an intensifying interest in this subject among researchers. This enquiry is not comprehensive but gives an idea of the trend.

Figure 2. Upward trend of research articles on microfinance - search results from ScienceDirect and PubMed since 1990s



2.2 Microcredit and health

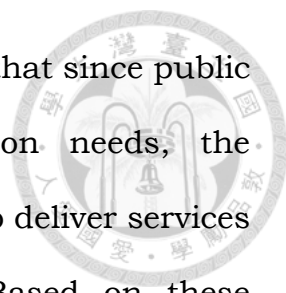


2.2.1 Health programs of MFIs

Poverty cannot be eradicated without addressing health (Waitzkin, 2003). Apart from credit services, many MFIs run non-credit social programs in areas such as health, education, rights awareness, training, disaster management and so on. In terms of health, a variety of programs exist, including health education and promotion, community health workers, linkages to provision of health services, access to health-related products such as drugs, health micro-insurance, loans to private health providers and direct provision of health care (Sheila Leatherman et al., 2011).

2.2.2 Motivations of MFIs' involvement in health

Motivations for MFIs to provide health care are both altruistic and egoistic. Saha (Saha, 2011) identified two business incentives. First, illness may cause business failure and loan default. In other words, healthy clients ensure regular repayment. Second, this approach served as an outreach tool for MFIs to get new clients. Nonetheless, MFIs are more likely to claim first that health services benefited the clients and the needy. In a survey conducted in 2010, 28 MFIs reported lack of health knowledge, lack of access to care and inability to afford care and medicine to be the main reasons for them to offer health services (Sheila



Leatherman et al., 2010). Microcredit advocates argued that since public health systems were inadequate to meet population needs, the microfinance sector should cash in on the opportunity to deliver services (Sheila Leatherman et al., 2011; Watkins, 2006). Based on these propositions some regarded NGOs to be important providers of public goods such as health and education in developing countries (Asadullah & Chaudhury, 2008; Asif Dowla, 2006; Durairaj et al., 2010; Sukontamarn, 2005).

2.2.3 Health impact of MFIs' credit and health programs

Studies that first evaluated health-related outcomes among borrowers saw positive impact of credit programs. One category of research examined whether participation in credit programs alone changed knowledge (N. Ahmed et al., 2006), behavior (Nanda, 1999) or health status. Another type of research investigated programs that combined microcredit with health elements from knowledge dissemination (Hadi, 2001, 2002) to access to basic care (Amin et al., 2001). Some review articles concluded that improved health was a clear benefit of microcredit in Bangladesh (Pronyk, Hargreaves, & Morduch, 2007; Schurmann & Johnston, 2009). However, studies of this kind were criticized to be limited by selection bias since participants are systematically different than non-participants.

On the other hand, increased psychological stress among microcredit

clients has been documented (Fernald, Hamad, Karlan, Ozer, & Zinman, 2008; A. Rahman, 1999), including a recent randomized control study in the Philippines that found declined subjective well-being among women borrowers (Karlan & Zinman, 2011).

In the field of health, proponents of microcredit analyzed the positive effects with Sen's capability approach (Sen, 2001). They explained that participation in microcredit increased poor borrowers' capabilities such as level of empowerment (Schuler, Hashemi, & Riley, 1997) and health capital through four possible pathways: economic, social, psychological and political. The four mechanisms operated by increased access to material resources, change of social norms, greater self-efficacy and ability to voice, all of which contributed to maintain and protect health. Thus, microcredit was linked with health (Sheila. Leatherman & Dunford, 2010; Mohindra & Haddad, 2005; Mohindra & Haddad, 2008)

Other researchers focused on the methodology of group-lending, also known as self-help group model. It has been an essential part in the operation of Grameen Bank, the pioneer in microcredit. Recognizing that mechanism from microcredit to better health was not always explicit, they also proposed a set of pathways including financing emergencies, financing health input, medium to health messages as well as increasing social capital (Schurmann & Johnston, 2009).



2.3 Microcredit and inequality

2.3.1 Social exclusion in MFIs' credit programs

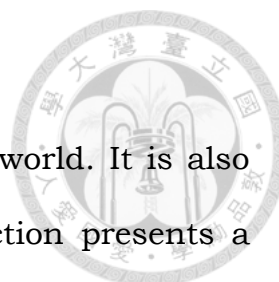
Microcredit is not without challenge. Social exclusion has been identified as a serious drawback of microcredit. Despite the mostly positive health outcomes, a group of research discovered that MFIs enhanced exclusion by keeping the poorest from their credit programs (Schurmann & Johnston, 2009). The extreme poor are not participating due to self-exclusion (S. R. Halder & Mosley, 2004), exclusion by fellow villagers (Hulme & Mosley, 1996) and exclusion by MFI staff that found them too risky to invest (Simanowitz, 2002). Evidence of exclusion implied that MFIs had not taken an inclusive approach to address poverty.

2.3.2 Social exclusion in MFIs' social program

Unequal access to credit programs raised another question as to whether similar problems occur in non-credit programs of MFIs. This is a much less researched area. One study assessed the health and education programs of two MFIs in three Bangladeshi villages (Atiur Rahman & Razzaque, 2000). The health program covered provision of family planning methods, basic curative care, water and sanitation, health education and immunization. Results showed that, like the credit operations, social programs were less participated by the extreme poor. In another study conducted in Uganda, it was also found that the

extreme poor were significantly disfavored in an MFI-supported health program (Ahmed & Zerihun, 2010).

On the other hand, non-credit programs of MFIs did report increased utilization, but they did not look into the distribution of users (Amin et al., 2001; Quayyum et al., 2013). And few, to the knowledge of the researcher, discussed the operation of MFI hospital care. This is probably due to the relatively small number in this business, but the number is increasing, thanks to the promotion of international advocates. For example, Microcredit Summit Campaign has worked since 2006 with Freedom from Hunger to establish an approach integrating microcredit and health services. The leading MFI in Bangladesh like BRAC also announced to open three hospitals. Recently, MFIs getting commercialized and drifting away from their social mission has become a concern (Armendáriz & Szafarz, 2011; Augsburg & Fouillet, 2010; Ghosh & Van Tassel, 2008). Whether current MFI hospital care is pro-poor and provided in underserved areas demands close examination. These are the claims made by MFIs and need to be substantiated. Under such circumstances, the research attempts to present evidence of the extent to which the poor population are using the MFI hospital care.



2.4 Context of study

Bangladesh introduced microcredit that swept the world. It is also the field where this research was conducted. This section presents a general introduction on this country and the situation of MFIs in the field.

2.4.1 Bangladesh

Located in south Asia, the People's Republic of Bangladesh came into existence in 1971 after a 9-month bloody independence war from the then west-Pakistan, at the cost of 3 million lives. Since then, social and political unrest, accompanied by frequent natural disasters remain harsh challenges to this country.



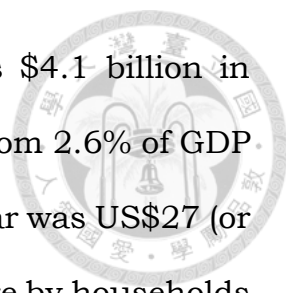
Figure 3. Map of Bangladesh

As Figure 3 shows, Bangladesh is surrounded by India on the east, north and west, Bay of Bengal to the south, with its south-eastern corner connecting Myanmar. The country currently accommodates 156 million people on the land of 147,570 sq. km. It is the seven largest country in the world in terms of population. Bangladesh experienced rapid urbanization from 15% living in urban areas in 1975 to 26% now (GoB, 2014a).

Table 2. Bangladesh at a glance

Population	156 million
Geography	Low-lying delta formed by Bramaputra and Ganges Rivers; frequent floods and cyclones
Government	Social democratic state (1975-1982) Military Control (1982-1991) Parliamentary democracy (since 1990s)
Religion	89% Muslim, 9.6% Hindu, 0.6% Buddhist, 0.3% Christian, and 0.17% others (DG Health, 2011)
Demographic, social and economic development	Adult literacy rate (M/F) 62/55 (2011) GDP per capita \$1,190 (2014) Life expectancy (M/F) 67/70 (2011) UNICEF Human Development Ranking 142 out of 187 (2014) Population below national poverty line 26% (2013) Annual GDP growth 6.1% (2014)

Source: Health Bulletin 2014, Ministry of Health and Family Welfare, Government of Bangladesh



Total health expenditure (THE) in Bangladesh was \$4.1 billion in 2012 or 3.5% of Gross Domestic Product (GDP), rising from 2.6% of GDP in 1997. Per capita expenditure on health in the same year was US\$27 (or \$68 in PPP terms). Out of pocket (OOP) health expenditure by households constituted the largest share and increased from 55.9% in 1997 to 59.9% in 2005, to 63.3% in 2012. On the other hand, the share of government spending in THE showed a decline from 37% in 1997 to 23% in 2012 (GoB, 2014b). Total health expenditure as a percentage of GDP in Bangladesh is relatively low in the Indian Subcontinent compared with India (3.8%) and Nepal (5.5%).

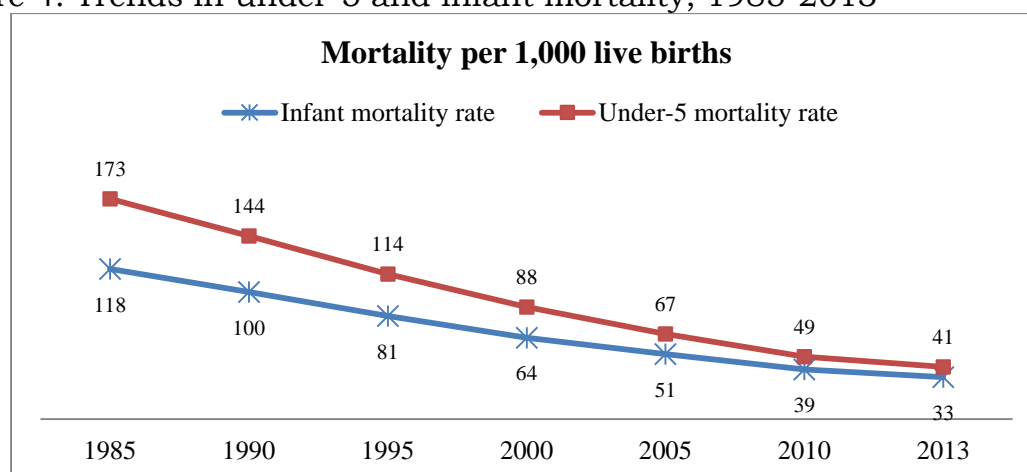
Despite low input from the public sector in health, vital indicators have shown substantial improvement, even better than neighboring countries like Bhutan, India, Myanmar, Nepal and Pakistan (table 3). Infant mortality rate (IMR) dropped from 118 in 1985 to 33 in 2013. Under-five mortality fell by more than two-thirds in the last decade from 173 in 1985 to 41 in 2013 (figure 4). Maternal mortality fell to 194 per 100,000 live births in 2010. Many believe that progress of IMR and MMR indicates that Bangladesh is on track to achieve MDGs target 4 (reduce infant mortality) and 5 (improve maternal health).

Table 3. Comparative health indicators across the region

	GDP per capita (US\$)	Total fertility rate	Life expectancy at birth		Mortality rates & ratio		
			Male	Female	infant	Under-5	
					Maternal		
Bangladesh	958	2.2	70	71	33	41	170
Bhutan	2,363	2.2	68	69	30	36	120
India	1,498	2.5	65	68	41	53	190
Myanmar	824	1.9	63	67	40	51	200
Nepal	694	2.3	67	70	32	40	190
Pakistan	1,275	3.2	66	68	69	86	170

Source: World Bank, 2013

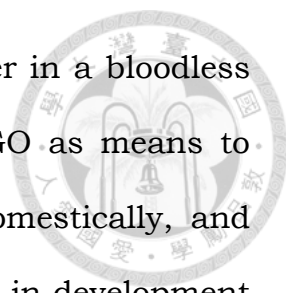
Figure 4. Trends in under-5 and infant mortality, 1985-2013



Source: World Bank, 2013

2.4.2 NGO-MFIs in Bangladesh

History of NGOs in Bangladesh dated back to the birth of the country. The first generation NGOs in the 1970s commenced their activities by providing relief and rehabilitation services in the war-torn country. Throughout the 1980s NGOs proliferated when General Hussain Muhammad Ershad reigned over the country, paradoxically, due to both



internal and international factors. After assuming power in a bloodless coup d'état, General Ershad encouraged growth of NGO as means to enhance legitimacy of his regime at the grassroots domestically, and respond to the global trend toward greater role of NGOs in development (Haque, 2002). At the same time, the model of Grameen Bank diffused across the country and induced existing and newly emerging NGOs to deliver credit (Zohir, 2004). In the 1990s the process of democratization, coupled with “New Policy Agenda” prescribed by western donor countries that favored NGOs instead of states, renewed the prominence of NGOs (Ahmad, 2000; Haque, 2002).

In 1990, the Government of Bangladesh established Palli Karma-Sahayak Foundation (PKSF), in English Rural Employment Support Foundation. It was, and is the apex organization that finances member MFIs or so-called Partner Organizations (POs) at low interest rate to carry out credit programs. Figure 5 showed the rapid growth of PKSF's partner organizations during the 1990s and then stabilized from the later part of 2000s. Similar to Grameen Bank, PKSF also has established a nationwide network covering all 64 districts with its 268 POs providing loans to 8 million borrowers (PKSF, 2015). Figure 6 shows PKSF's nationwide coverage, where each dot represents a PO. Through PKSF, the state is able to exercise financial and regulatory power over a large number of MFIs. Overall, strong support from national government and international donors facilitated the practice.

Figure 5. Growth of PKSF's partner organizations, 1991-2014




http://www.pksf-bd.org/index.php?option=com_content&view=article&id=494&Itemid=282

Figure 6. National coverage of PKSF



http://www.pksf-bd.org/index.php?option=com_mapping&Itemid=284



Microcredit Regulatory Authority (MRA) was established in 2006 under the Bangladesh Bank. The first assignment of MRA was licensing NGO-MFIs. In the first round 4,241 NGO-MFIs sent application for licenses but as of May 2014 only 742 NGOs acquired licenses (MRA, 2014). Official estimates indicated that approximately 4,176 NGOs worked in the health sector (GoB, 2010). A World Bank publication in 2007 reported that 90% of NGO offices all over Bangladesh (including headquarters and branches) offered microcredit as their core activity. The distinction between NGOs and MFIs often gets blurred and the name NGO-MFI or MFI-NGO emerged as a result (Zohir, 2004). Among the *Forbes* 'Top 50 MFIs' around the world, seven are based in Bangladesh, the single country that has the highest number of MFIs.

Today the concept of microcredit has been widely accepted by people in Bangladesh. Unlike the early days when loan officers had to visit door to door to solicit members, most poor people now can choose from more than one MFIs in their village to borrow money from or save with. While recruiting new borrowers, MFIs offer more loans for active members, upgrading them to micro-entrepreneurs. The number of microcredit clients in 2013 was 24.6 million, taking up 15% of the total population, served by some 700 MFIs (MRA, 2014).

Through disbursing loans, MFIs charge annualized interest rates ranging from 12% to 40%. Average loan size is normally less than 10,000 Bangladeshi taka (about USD135). High interest rate and large pool of

clients make it a highly profitable business. For non-profit organizations that used to suffer from chronic financial constraints, engaging in microcredit has brought revenues and continuous influx of funds. The latest statistics shows that MFIs have become less and less dependent on PKSF or donor funds as clients' savings and cumulative surplus make up the major source of funding (Table 4).

Table 4. Composition of MFI sources of fund 2009-2013

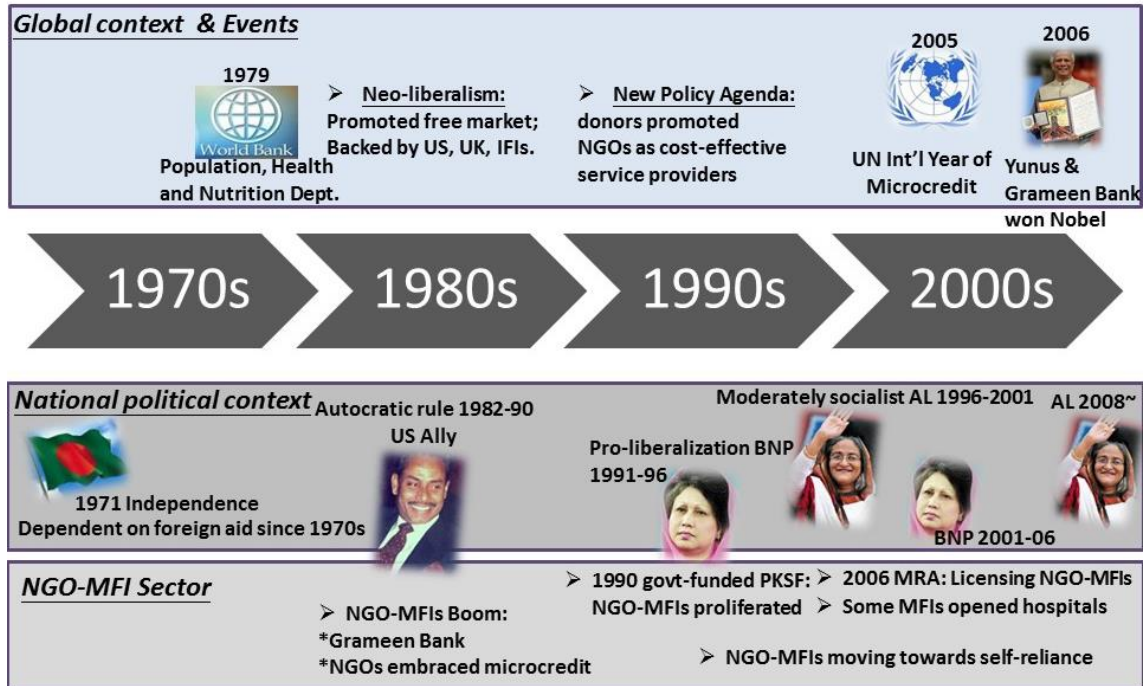
Source of Fund	2009		2010		2011		2012		2013	
	Mil.BDT	(%)	Mil.BDT	(%)	Mil.BDT	(%)	Mil.BDT	(%)	Mil.BDT	(%)
Clients' Savings	40,527	30	47,436	31	63,296	35	74,989	33	91,178	33
Loan from PKSF	22,666	17	24,484	16	31,768	17	33,577	15	34,072	12
Loan from Commercial Banks	23,896	18	23,006	15	23,578	13	32,652	14	42,699	15
Donors' Fund	4,110	3	4,109	3	7,008	4	7,061	3	7,105	3
Cumulative Surplus	36,262	26	42,339	28	50,299	27	65,438	28	83,262	30
Other Funds	8,848	6	10,907	7	7,727	4	16,168	7	18,391	7
Total	136,309	100	152,281	100	183,676	100	229,885	100	276,707	100

Source: MRA-MIS Database, 2013

Figure 7 summarizes this section by illustrating the course of the NGO-MFI development in national and global context.



Figure 7. National and global context of NGO-MFI development



2.4.3 Health Care Delivery System in Bangladesh

The government of Bangladesh (GoB) established extensive health and family planning setup for the people, particularly in rural areas, at nearly no cost. As its name suggests, the highest governing body of health affairs, Ministry of Health and Family Welfare places dual emphases on health and family planning.

Structure of health services in Bangladesh follows the administrative structure (Figure 8). In each district the civil surgeon is responsible for managing secondary and primary care services. There is a district hospital for every district providing secondary care. At the upazila (sub-district) level, the upazila health and family planning officer manages all public health programs and runs the upazila health complex, equipped with a 30-50 bed in-patient department, an out-patient department and a family planning unit. At the union level, each health facility employs a medical doctor and covers a population of around 7,000. At the ward level are community clinics. Each community serves 6,000 people by one community healthcare provider (CHCP), who is supported by Health Assistant and Family Welfare Assistant. All facilities at upazila and below are regarded as “primary level” (GoB, 2014a).

Regarding utilization, figure 9 displays the distribution of outdoor patients and admissions by type of public health facility in 2013. In the case of outdoor services, 71% of patients used primary care. In case of indoor services, the most used was still primary-level hospitals at 45% (GoB, 2014a).

In addition to public facilities mentioned above, NGOs and private sector are also providing health care at almost every level through for-profit or not-for-profit facilities. A recent report (D. Balabanova, McKee, & Mills, 2011) documented the rapid growth of the private sector by 15% per year.

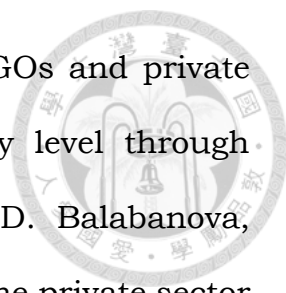
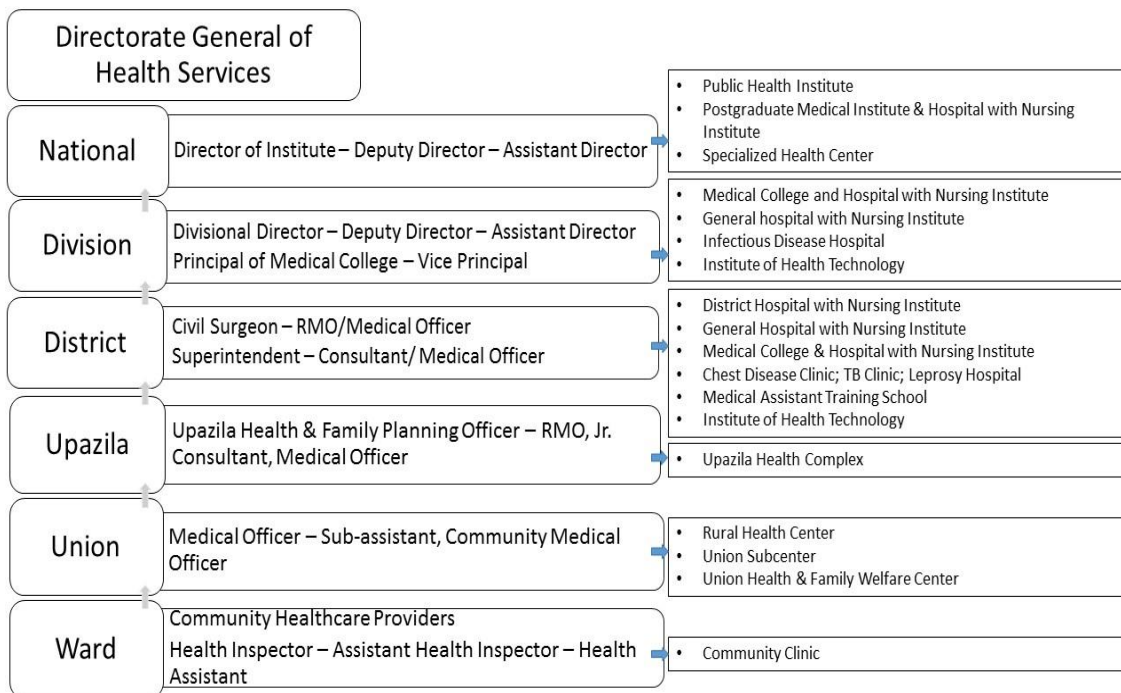
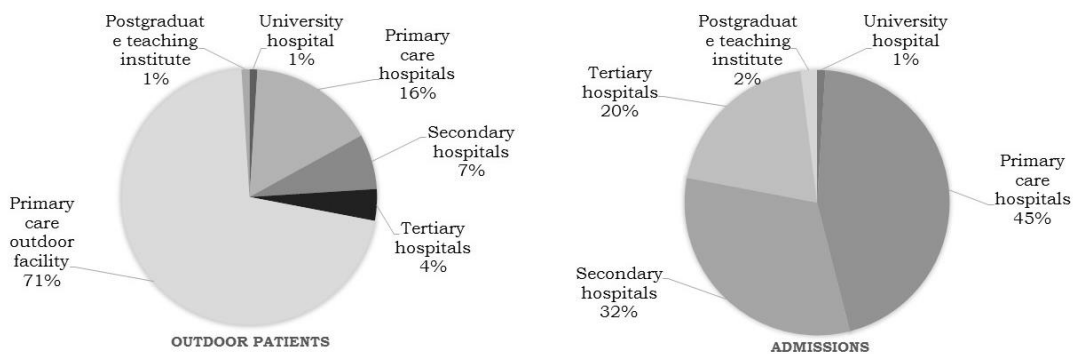


Figure 8. Health Care Management and Delivery Hierarchy



Source: Health Bulletin 2014

Figure 9. Distribution of outdoor patients and admissions by type of facility, 2013

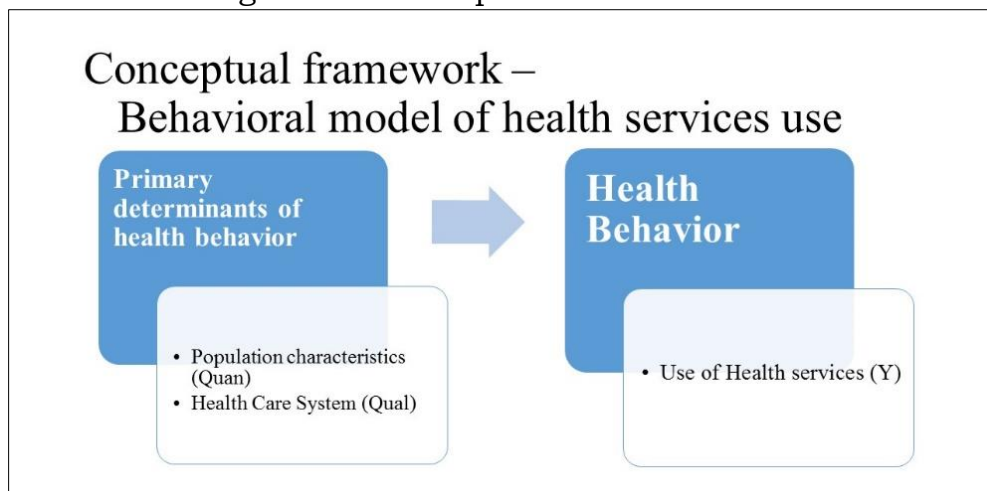


Source: Health Bulletin 2014

2.5 Conceptual framework

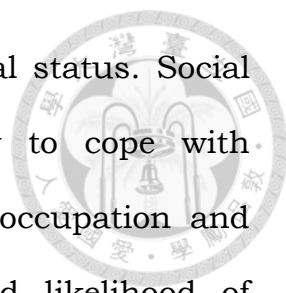
Figure 10 shows the conceptual framework for determinants of MFI hospital utilization. The research employed the widely used Behavioral Model of Health Services Use developed by Ronald M. Andersen to lay out factors that influence utilization of medical care (Aday & Andersen, 1974; Andersen, 1995). According to the model, usage of health services is determined primarily by population characteristics and health care system.

Figure 10. Conceptual framework



The first part of the research used a structured questionnaire to explore the association between hospital use and population characteristics, and the second part explored the relationship between hospital use and health system through in-depth interviews.

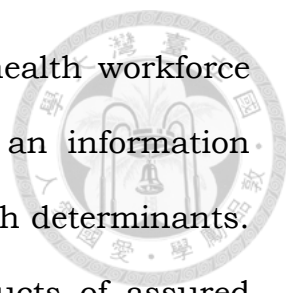
In the quantitative research, population characteristics can be categorized into three groups: predisposing, enabling and need. The predisposing group encompasses demographic and social structural factors. Demographic factors which suggests the likelihood of using



health care are represented by age, gender and marital status. Social structural factors determines an individual's ability to cope with problems and can be measured by one's education, occupation and ethnicity. Enabling factors represent the means and likelihood of individuals to obtain services. These factors would include: the existence of health facilities and manpower, wealth, distance to facilities, transportation, health insurance and other context-specific measures. Last, the model investigates needs, that is, how people perceive the state of their general health, how they experience health conditions and whether they think the problems need medical intervention. Utilization takes place only when the need for care (either perceived or evaluated) – the most immediate cause of health service use – emerges. Additionally, Andersen noted that organizational factors improved our ability to explain use, so I presented consultation charges incurred after actual use, but did not include it in the model (Andersen, 1995).

In the qualitative research, I explored the relationship between use and health care system. Health care system can be examined by some established components since a health system has to provide services, health workers and key resources; to mobilize and allocate finances; ensure leadership and governance/stewardship, meaning oversight and guidance of the whole system (WHO, 2007b).

A good health system, according to the World Health Organization, delivers effective, safe, quality personal and non-personal health interventions to those who need them, when and where needed, with



minimum waste of resources. It has well-performing health workforce that is fair, competent and responsive. It maintains an information system that ensures use of reliable information on health determinants. It ensures equitable access to essential medical products of assured quality, safety, efficacy and cost-effectiveness. It raises adequate funds for health and ensures that users are protected from financial catastrophe. Last but not least, it involves good leadership and governance. These characteristics can be used to assess health care system and other activities directly and indirectly contributing to health (WHO, 2000). Detailed analytical frameworks of two separate approaches were displayed in the following chapters.

Chapter 3 Questionnaire Survey



3.1 Study objectives

The survey aimed to compare patients in two types of hospitals and present the extent to which MFI hospitals served the poorest. In light of existing literature indicating an exclusion problem in MFIs' credit and social programs (Ahmed, Petzold, Kabir, & Tomson, 2006; Ahmed & Zerihun, 2010; S. R. Halder & Mosley, 2004; Hermes & Lensink, 2011; Atiur Rahman & Razzaque, 2000; Schurmann & Johnston, 2009) it was hypothesized that, compared with public hospitals, MFI hospitals might serve patients from higher income groups, charge higher fees, and might be used more by microcredit beneficiaries.

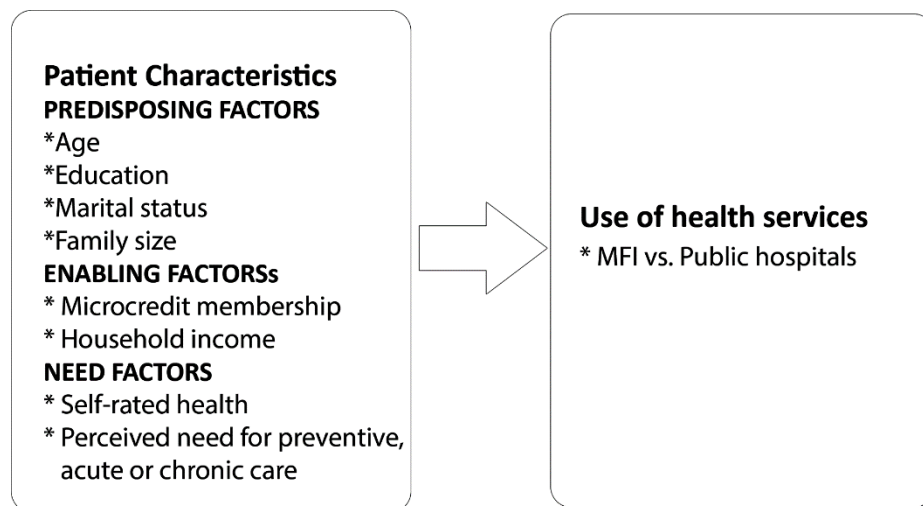
3.2 Methods and materials

Analytical framework

This research employed the widely used Behavioral Model of Health Services Use. Usage of health services is determined primarily by three sets of population characteristics which are predisposing, enabling and need. It focused on how MFI hospital utilization was characterized by the socioeconomic positions of female patients. Guided by theoretical and empirical studies in South Asian countries (Amin et al., 2010; Amin et al., 2001; I. Anwar et al., 2008; Chakraborty, Islam, Chowdhury, Bari, & Akhter, 2003; Quayyum et al., 2013; Subedi, 1989), the author developed the conceptual framework and questionnaire accordingly.

It is noteworthy that this research did not intend to repeat the same story of lower utilization of those in lower socioeconomic strata. The research specifically examined if the poor-rich divide was narrower in health care facilities operated by organizations with an explicitly stipulated pro-poor mission.

Fig. 3.1 Analytical framework for determinants of MFI hospital utilization



Study design and setting

This health services research used information from a cross-sectional survey of outpatients in public and MFI hospitals in Bangladesh. Criteria for the selection of hospitals were determined as follows. First, they must be general hospitals, not specialized such as MCH, cancer or diabetic hospitals. Second, non-public hospitals had to be managed by microfinance institutions with a clear mandate to serve the poor. This criterion excluded non-MFI NGO or private charity hospitals. Third, for better comparison, study sites were where MFI and

public hospitals operated as closely to each other as possible and where no private hospitals existed. Finally, selection also took into consideration security, time constraints and availability of transport options.

Table 5 shows the basic information of the sites, hospitals and number of respondents. District K is in the rural north bordering India and the remotest of the three sites. District S is northwest of the capital Dhaka, semi-urban and well-connected by good transportation links. District J is an urban area next to the capital, an industrial and commercial zone with all forms of transport.

In each selected district there is one district hospital in town providing general and specialized care, with 100, 250 and 100 beds, respectively. Healthcare outside the town is available at sub-district health complexes and community clinics. The private sector is active, but not operating full-fledged general hospitals in the study areas. The three MFIs were established in the late 1980s, and introduced microcredit during 1990-1994, basic health programs during 1996-1999, and hospitals in 2004 and 2010 on the basis of serving the poor at low cost. Though small in scale, the respective 22-, 50- and 70-bed hospitals were equipped with general physicians, X-ray, family planning, physiotherapy, immunization, ultrasonography, antenatal & postnatal care, ECG, pathology and, specialist care namely medicine, surgery, gynecology/obstetrics, pediatrics, ophthalmology, ENT, orthopedics, cardiology and so on.



Table 5. Site and hospital characteristics

Site characteristics^a			
	K	S	J
District code			759
Area of district in sq. km	2,841	3,424	
# of households	479,000	866,800	671,200
Average household size	4.6	4.1	4.3
# of district hospitals	1	1	1
# of MFI that runs hospitals	1	1	1
Total # of doctors in the district	134	323	154
Hospital characteristics			
Publicly run district hospital^b			
Location in district	District town	District town	District town
# of beds	100	250	100
# of patients in 2012	111,112	245,238	291,040
# of doctors (full-time)	16	47	33
# of respondents	53	46	71
MFI-run hospital^c			
Location	District town	District town	District town
Year started	2010	2004	2010
# of beds	22	50	70
# of patients in 2012	10,800	56,445	26,212
# of doctors (full-time & part time)	22	16	24
Population coverage	n.a.	3.9 million	2.1 million
# of respondents	42	59	76
Services and facilities ^d	1-8, 10-11, 13-15,17-18	1-7, 9-10,12-18	1-6, 8-19

Sources:

^aGeneral information from Population & Housing Census 2011, Bangladesh Bureau of Statistics

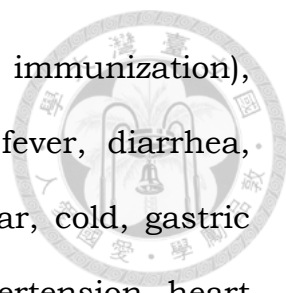
^bHealth indicators from Health Bulletin 2013 & 2014, MoHFW Bangladesh

^cMFI information from 2012 annual reports of MFIs

^dServices include 1) Family planning, 2) ANC & PNC, 3) Immunization, 4) Medicine, 5) Surgery, 6) Gynaecology/obstetrics, 7) Cardiology, 8) ENT, 9) Eye, 10) Paediatrics, 11) Orthopedics, 12) Physiotherapy, 13) Pathology, 14) Ultrasound, 15) ECG, 16) X-ray, 17) Pharmacy, 18) 24 hours, 19) ICU

Data collection

The survey collected independent variables of age, level of education, marital status, family size, microcredit membership and duration, monthly household income, self-rated health, perceived needs for

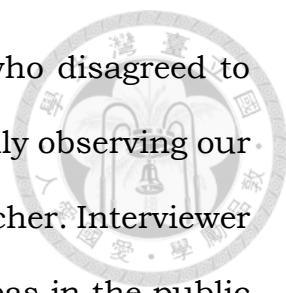


preventive care (e.g. health check-up, maternal care, immunization), acute conditions (obstetric & gynecologic treatment, fever, diarrhea, accident/injury, acute conditions of the eye, skin or ear, cold, gastric pain, pneumonia) or chronic conditions (diabetics, hypertension, heart disease, weakness, long-term problems of the eye, skin or ear). Amount of consultation fees was asked as supplementary data. This item was fixed in two types of hospitals and might represent ease of access.

The outcome measurement was utilization of an MFI hospital. Utilization was coded when a female respondent visited and received health service in an MFI hospital. Non-utilization was coded when a female respondent visited and received health service in a public hospital.

Sex is a typical predisposing factor. The study recruited only female patients as women are usually the most vulnerable and represent 93% of all borrowers (MRA, 2011). Regarding age, the minimum legal age for a woman to marry in Bangladesh is 18, but in reality one-third of women aged 20-24 were married by the age of 15 (UNICEF, 2011). The inclusion threshold was set at 15 taking into account the need for maternal care among young married women.

Trained surveyors employed convenience sampling when conducting face-to-face interviews with patients. In MFI hospitals, interviews were completed in the waiting areas. During the survey not many outpatients in MFI hospitals were spotted and there seemed to be peak and off-peak times. Two to three surveyors worked simultaneously so we had enough time to approach mostly all eligible patients and finish our work without



missing potential respondents. There were only a few who disagreed to cooperate initially but later consented either after carefully observing our work or after being approached again by the main researcher. Interviewer screening was minimal in MFI hospitals. The waiting areas in the public hospitals, on the other hand, had a large number of patients and few seats. Interviewing under such circumstances appeared inappropriate.

Arrangements were made so a corner was used by the interviewer next to the consulting room. As soon as one interview was completed, the surveyor approached the next available patient. The survey achieved a zero-rejection rate. Possible explanations for high level of cooperation are: one, patients considered the questioning to be part of the consultation, and two, surveyors having a chair and desk to work at may have given the appearance that it might be hospital business they should comply with. These considerations should be kept in mind for future studies. Low rejection precluded the occurrence of interviewer-related selection bias.

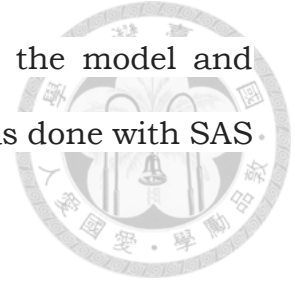
Ethical approval was obtained from the Research Ethics Office of National Taiwan University (NTU). The Ministry of Health & Family Welfare (MoHFW) in Bangladesh and respective MFIs approved the research. Written consent was difficult to obtain due to high illiteracy rate among women, which was 48.61% in rural and 34.05% in urban areas (BBS, 2010). A written consent form was read out loud and explained to potential respondents. Upon receipt of informed verbal consent from each respondent, the investigators began the interview. Use of oral consent was approved by the Research Ethics Office of NTU and MoHFW.

Data analysis

A total of 379 subjects were interviewed but 32 were incomplete. 347 subjects were included in the analysis. Descriptive analyses were performed to present the distribution of socioeconomic characteristics of respondents in two types of hospitals. To understand whether the current hospital were also the hospital the respondents preferred in need of hospital care, the researcher tested and confirmed that “current user of MFI (or public) hospital” and “frequent user of MFI (or public) hospital” were highly associated ($p < .0001$). Second, bivariate associations between independent and outcome variables were examined using the chi-square test. Generalized Estimating Equations (GEE) has been regarded a suitable method to analyze correlated binary responses arising from the relatedness of individuals in the same cluster (Galbraith, Daniel, & Vissel, 2010; Hanley, Negassa, & Forrester, 2003). In the present study, data collected in three different districts was likely to be clustered and correlated. Therefore, observations from the same district could not be treated as if they were independent. As typical logistic regression does not account for correlation within each area cluster, the GEE approach allowed the researcher to properly use all data to estimate the relationship between patients’ primary determinants and health behavior, taking into consideration the clustering effects within particular areas. By doing this, a more robust inference could be made. Parameter estimates generated by GEE were then converted into odds ratios. The author further examined the simultaneous effects of microcredit

membership and income by creating new variables in the model and adjusting for confounding factors. Statistical analysis was done with SAS

9.3 (SAS Institute, Cary, NC, USA).



3.3 Results

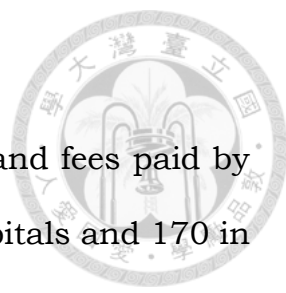


Table 6 displays the socioeconomic characteristics and fees paid by study subjects. There were 177 respondents in MFI hospitals and 170 in public hospitals. Mean age was 31 (SD=13.02) and 35 (SD=12.95) years in MFI and public hospitals, respectively. MFI hospitals had a higher percentage (67.23%) of younger patients between 15 and 30 years old than the public hospitals (44.12%). The majority of respondents were married. In MFI hospitals those with 5-9 and 10+ years of education accounted for 32.37% and 26.59%, while in public hospitals the largest subgroup was the one without any education, at 37.72%. The percentages of microcredit members in MFI and public hospitals were 31% and 26%, respectively. Microcredit borrowers in MFI hospitals had a slightly longer history of membership (4.64 years, SD=5.01) than those in public hospitals (4.22 years, SD=5.50). The mean family size was about 5 persons in both settings. About 70% of the respondents in MFI hospitals had a monthly household income over 8,000 Bangladeshi Taka (US\$103) and 5.68% reported a household income below 4,500 taka (US\$58). In contrast, 46.67% of patients at public hospitals had a household income over 8,000 taka and 25.45% were below 4,500 taka. Regarding self-assessed health, after merging small-sized subgroups, 53.45% of patients in MFI hospitals reported good health (excellent, very good, good and fair versus bad health), much higher than 24.26% in public hospitals. The majority of patients (83.53%) visited public hospitals for acute conditions, but more patients visited MFI hospitals for preventive services

(45.20%) than for their acute (37.85%) or chronic conditions. Consultation fees at public hospitals were mostly < 50 taka (98.82%). The exact fee was 5 taka only. In MFI hospitals, the majority paid between 100 and 500 taka (74.43%). Bivariate analysis found significant differences between the two groups regarding age, marital status, education, household income, self-rated health, perceived need and cost.

Table 6. Patient characteristics and cost of care in MFI and public hospitals

	MFI hospital (n=177)	Public hospital (n=170)	p
Age (years)			***
15 – 30	67.23% (119)	44.12% (75)	
≥31	32.77% (58)	55.88% (95)	
Mean age	31.19 (SD13.02)	35.27 (SD12.95)	
Education (years)			*
0	24.86% (43)	37.72% (63)	
1-4	16.18% (28)	16.77% (28)	
5-9	32.37% (56)	30.54% (51)	
10+	26.59% (46)	14.97% (25)	
Marital Status			**
Currently married ^a	93.10% (162)	84.12% (143)	
Family size (mean)	5.13 persons (SD 2.05)	4.99 persons (SD 1.97)	
Microcredit membership			
Zero membership (non-member)	69.49% (123)	74.71% (127)	
Short-term membership (< 5 years)	19.21% (34)	18.24% (31)	
Long-term membership (≥5 years)	11.30% (20)	7.06% (12)	
Mean among members	4.64 (SD=5.01)	4.22 (SD=5.50)	
Household Income			***
Poorest (≤4,500 taka)	5.68% (10)	25.45% (42)	
Moderate (4,501-8,000 taka)	23.30% (41)	27.88% (46)	
Non-poor (≥8,001 taka)	71.02% (125)	46.67% (77)	
Self-rated health			***
Good	53.45% (93)	24.26% (41)	
Poor	46.55% (81)	75.74% (128)	
Perceived need			***
Preventive services	45.20% (80)	7.06% (12)	
Acute conditions	37.85% (67)	83.53% (142)	
Chronic conditions	7.34% (13)	9.41% (16)	
Cost (consultation fee)			***
<50 taka	17.61% (31)	98.82% (168)	
50-100 taka	6.25% (11)	0% (0)	
100-500 taka	74.43% (131)	1.18% (2)	
>500 taka	1.7% (3)	0% (0)	

*p<.05; **p<.01; ***p<.001 (chi-square test).

^aOthers - never married, separated, divorced, widowed.

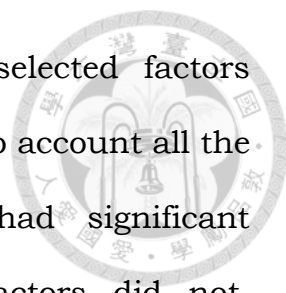


Table 7 presents the adjusted odds ratios of selected factors associated with MFI hospital utilization. After taking into account all the covariates, only the enabling and need factors had significant associations with MFI hospital use; predisposing factors did not. Compared with patients who did not participate in any microcredit program, patients with a longer history of microcredit membership were more likely to use MFI hospitals (OR=2.90, 95% CI: 1.46-5.75 for membership more than 5 years). Income level showed a clear gradient with utilization. In comparison with public hospital respondents, moderately-poor and non-poor were 4.09 times (95% CI: 3.27-5.12) and 7.34 times (95% CI: 2.05-26.31) more likely than the poorest to go to an MFI hospital. There was an increased likelihood for those reporting good health to utilize an MFI hospital, but the association was not significant. In terms of perceived need, the odds ratio of patients using MFI hospital for preventive care was 3.4 (95% CI:1.43-8.07). However, there was a significantly negative association with the need for acute care (OR=0.26, 95% CI: 0.08-0.90).

Table 7. Adjusted odds ratios (and 95% confidence intervals) of factors associated with MFI-hospital utilization

	Adjusted OR (n=347)	95% CI
<u>Predisposing factors</u>		
Age (ref. ≥ 31 years)		
Young (15-30 years)	1.28	0.62 - 2.62
Education (ref. 0~4 years)		
≥ 5 years	1.03	0.53 - 2.04
Marriage (ref. unmarried)		
Married	1.32	0.65 - 2.69
Family size		
	1.02	0.83 - 1.24
<u>Enabling factors</u>		
Microcredit membership (ref. zero membership)		
Short-term membership (<5 years)	1.54	0.60 - 3.94
Long-term membership (≥ 5 years)	2.90**	1.46 - 5.75
Income level (ref. poorest)		
Moderately poor (4,501-8,000 taka)	4.09***	3.27 - 5.12
Non-poor ($\geq 8,001$ taka)	7.34**	2.05 - 26.31
<u>Need factors</u>		
Self-rated health (ref. poor health)		
Good health	1.78	0.84 - 3.74
Perceived need (ref. chronic care)		
Preventive care	3.40**	1.43 - 8.07
Acute care	0.26*	0.08 - 0.90

*p<.05; **p<.01; ***p<.001

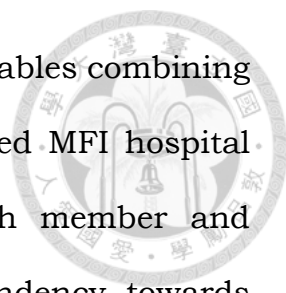


Table 8 provides the adjusted odds ratios of new variables combining income level and microcredit membership that predicted MFI hospital use. Besides a gradient along income levels in both member and non-member subgroups, the former had a higher tendency towards utilization.

Table 8. Adjusted odds ratios of combined factors to predict MFI hospital use

Income level	Membership with MFI			
	Membership with MFI		Non-member	
	OR	(95% CI)	OR	(95% CI)
Non-poor	7.46***	(2.51-22.14)	4.48**	(1.82-11.07)
Moderately poor	6.91***	(3.68-12.96)	1.91	(0.99-3.68)
Poorest	0.42	(0.12-1.52)	1 ^b	(ref.)

*p<.05; **p<.01; ***p<.001

^aThis model adjusted for age, marital status, education, family size, need and self-rated health.

^b Reference group: those with the poorest household income and without membership in any microfinance institution.

Compared with the group who were non-members and the poorest, microcredit members who were non-poor had the highest likelihood (OR=7.46, p<.001) to visit MFI hospitals, followed by members with moderate income (OR=6.91, p<.001) and then non-members in non-poor households (OR=4.48, p<.01). Those who were members but the poorest had a negative association (OR=0.42), though not significant.

Chapter 4 Qualitative study



4.1 Study objectives

This part of study explored stakeholders' perspectives on the provision of hospital care in the public and MFI sectors through in-depth interviews, field observations and web-based research. It tried to address the following questions:

1. How does hospital care provided by MFIs contribute, or whether it does contribute, to strengthen the complementarily working relationship?
2. Whether policies implemented in MFI hospitals and health-related activities have been aligned with government policy and narrowed the equity gap?
3. What are the implications of these MFI hospitals and health-related activities on the health care system?

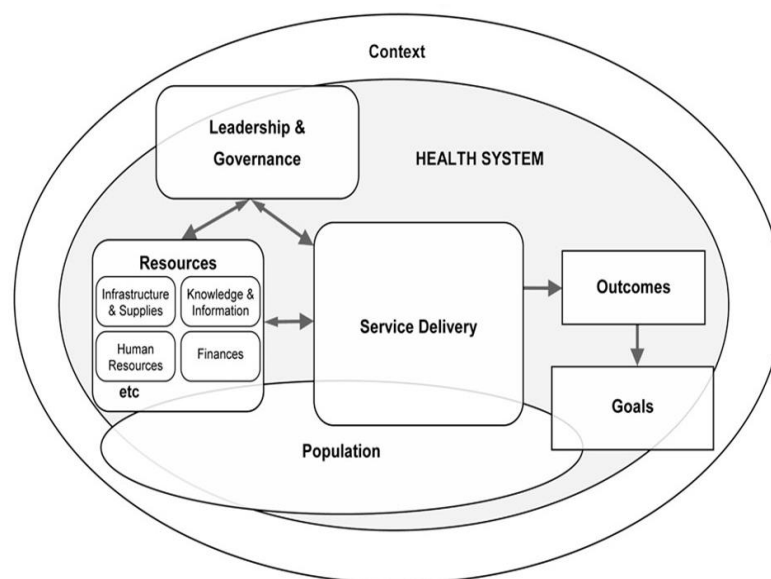
4.2 Methods and materials

Analytical framework

The WHO, a prime promoter for health system strengthening, indicated the structural elements of the system which included service delivery, health workforce, information, medical products, financing, and leadership and governance, also known as the “6 building blocks framework” (WHO, 2007a). Following on this framework that

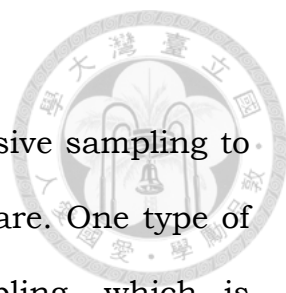
conceptualized and described health systems, the Health System Dynamics Framework, added four new elements – population, context, goals and values – and highlighted the dynamic relationships between the elements, as shown in Figure 11 (Van Olmen, Criel, et al., 2012). The framework perceives *“health systems as social systems that are embedded in a context that shapes its design and development and that in turn emanate the prevailing values of the society to which they belong.”*(van Olmen, Marchal, Van Damme, Kegels, & Hill, 2012), *“outcomes are defined as direct results of the organization of health care delivery, and goals are defined as the expected impact in terms of improved health and social and financial protection”*. It weighs governance, human resources, service delivery and population more than other elements, with the population playing a central role. It appeared to be a suitable framework for analysis.

Figure 11. Analytical framework for microfinance-based health care system



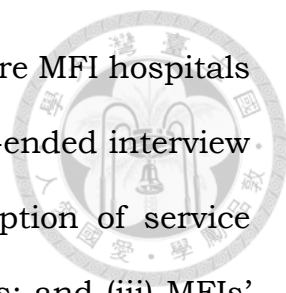
(van Olmen et al., 2012)

Study population



Targeted individuals were recruited by using purposive sampling to ensure inclusion of key informants from two types of care. One type of purposive sampling technique is critical case sampling, which is particularly useful in exploratory research and research with limited resources. Critical cases are subjects who exercise great influence over the issue of researcher's interest. The method permitted logical generalization and maximum application of information to other cases. (Crabtree & Miller, 1999) For example, one of the critical cases in the research was the chief executive officer at the government-founded Palli Karma-Sahayak Foundation (PKSF) which disburses seed capital for its nationwide partner organizations (retailer MFIs) to carry out microcredit services as well as sets policies for partner MFIs. The respondents were naturally identified as soon as particular hospitals and their competent authorities were decided. They included individuals who managed or oversaw hospital-based health programs in (i) local government bodies (ii) central government agencies (iii) MFI headquarters, and (iv) hospitals, located in three study areas and Dhaka the capital. Additionally, (v) users who received questionnaire might answer a few open-ended questions when time permitted.

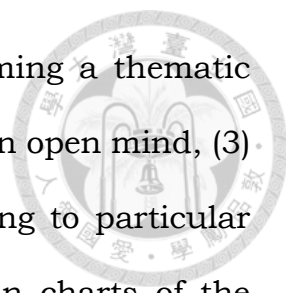
Requests for interviews were made by email using a standard script. All that were contacted consented with return email by themselves or their assistants. Face-to-face interviews were conducted during August and September 2013 in Dhaka with central government officers and one



MFI program director, and in selected district towns where MFI hospitals operated. The interviewer used a semi-structured, open-ended interview outline that focused on the following areas: (i) description of service delivery; (ii) comparison of public and MFI-run hospitals; and (iii) MFIs' role in the healthcare delivery system, complimentary or contradictory; (iv) implications of MFIs in health system. The strength of semi-structured interview was that since questions were open-ended and respondents were not limited by specific given choices, a favorable atmosphere could be created for the interviewer and interviewee to discuss the topic at length. In the meantime, the interviewer used cues and prompts to direct the respondent into areas of interest to obtain in-depth information. The interviewer audio taped the entire question-answer session, except for one with a government official who declined, and took notes during each interview. Most of the respondents were generous with their time and interviews lasted for two hours averagely.

Data analysis

Framework analysis method has been useful for applied policy research in which specific questions, pre-determined subjects and a priori issues existed. To describe and interpret what is happening in a particular setting is a prime concern of this method (Ritchie & Spencer, 2002; Srivastava & Thomson, 2009). The method involve five steps: (1) familiarization – the researcher becoming immersed in the data, (2)



identifying a thematic framework – the researcher forming a thematic framework based on a priori themes or issues but with an open mind, (3) indexing – identifying portions of the data corresponding to particular themes, (4) charting – pieces of data being arranged in charts of the themes, and (5) mapping and interpretation – forming a schematic diagram of the phenomenon guiding the interpretation of the data set (Ritchie & Spencer, 2002). Finally, results generated from the interviews were combined with findings from the quantitative study.

Ethical consideration

The study protocol was reviewed and approved by the Research Ethics Office of NTU. Before each interview, the researcher and local interviewees explained research objectives, process and confidentiality issues, and obtained oral consent. A token from the NTU College of Public Health was presented in appreciation of their cooperation.



4.3 Results

The part presented the characteristics of MFI and public hospitals, followed by a comparison arranged by the main features of the health system.

4.3.1 Respondent Characteristics

Table 9 shows a list of the types of respondents in the study. The first category of respondents was the administrative head of the district. This position is appointed by the central government. The chief chairs monthly coordination meetings with NGOs working in the district. About NGO and NGO-MFI activities in their jurisdiction some were more informed than others. Two of them could tell the exact numbers of the NGOs working in the district and most of their activities.

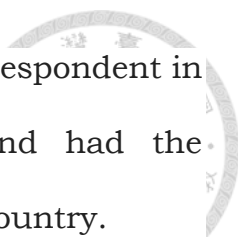
The second category of respondents is the civil surgeons, who manage all district level (and below) health activities from food, health, nutrition, preventive (like vaccination) and curative services that include hospital, medicine, patient diet, public health data collection and reporting, surveillance, supervision and monitoring of public, non-governmental and private health facilities. Civil surgeons also have knowledge about the MFI hospitals, including the size and staff qualifications and employment conditions. All the three civil surgeons have been in public services for 30 years.



Table 9. Categories and positions of participants

Case No.	Category	Description	
1	Local government officials	Chief administrative officer in the district K	
2		Chief administrative officer in the district S	
3		Chief administrative officer in the district J	
4		Civil surgeon in District K & superintendent of district hospital	
5		Civil surgeon in District S	
6		Civil surgeon in District J	
7		Head of upazila (sub-district) health complex	
8	Central governing body	Chief of the regulation agency	
9	MFI financing organization	Chief of the microcredit umbrella organization	
10	Health Ministry	Additional secretary	
11	MFI management	Board member of MFI K	
12		Program director of MFI K	
13		Program director of MFI S	
14		Executive director of MFI S	
15		Senior advisor of MFI J	
16		Hospital care provider	Superintendent of public hospital in district K
17			Staff of public hospital in district K
18			Superintendent of MFI hospital K
19			Superintendent of MFI hospital S
20			Superintendent of MFI hospital J
21	Medical officer MFI hospital		
22	Medical officer in public hospital		
23	MFI community health worker		
24	Patient	Patient in MFI hospital S	
25		Patient's husband in MFI hospital J	
26		Patient's husband in MFI hospital J	
27	Academic	Professor of Economics in Dhaka University	

The third group was policy makers, who also played the role of regulators. PKSF managed 268 MFIs and Microcredit Regulatory



Authority (MRA) had 742 MFIs reporting to them. Another respondent in the health ministry used to be a women activist and had the responsibilities to organize community clinics around the country.

The fourth group of respondents belonged to the MFI sector. Those being interviewed included three health program in-charge, three hospital directors, one MFI head, and one medical officer. A few respondents received the researcher while they were working, so a complete interview might take place in the car while the respondent was traveling from one place to another, or in and out the chamber at intervals between patient visits, or at different hours of the day whenever the interviewee was free. Despite the inconvenience, they were cooperative with the researcher's request.

In the patient group, one was a female patient accompanied by a traditional birth attendant (TBA) in MFI Hospital S and the other two were husband who accompanied his pregnant wife in MFI Hospital J and spoke some English. The first respondent was a 30 years old woman who came for her diabetic. She reported monthly income around 10,000-15,000 taka. Her husband worked in Saudi Arabia. The second respondent worked with a life insurance company. The third respondent was a businessman. Information indicated that the latter two respondents did come from poor households.

4.3.2 Public hospitals

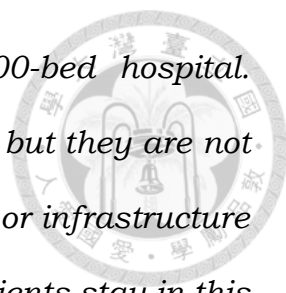
Service delivery

Outpatient department (OPD) in public hospitals ran from 8 am until 2:30 pm (6 .5 hours), Saturday through Thursday, six days a week. A few medical officers (exact number varied according to size of the hospital or sanctioned number) attended patients in the OPD. They were the first care providers patients came to touch with. If needed, they would refer patients to consultants who also sat in the outdoor waiting for the referred patients, treating or admitting them.

Official statistics showed bed-occupancy rate in District Hospitals in K, S and J were 165%, 146% and 106%, respectively (GoB, 2014a). The health officials pointed out that huge crowds of indoor and outdoor patients against existing structure and under-staffed capacity was the greatest challenge. In the hospital of 250 beds, more than 400 patients were admitted every day. Many inpatients were poorly accommodated, having to lie on the sponges arranged on the floor.

“Excess 150 (patients) gets no bedsheet, no bed, no diet, but we try to give them some medicine on humanitarian ground... we have to manage them as far as possibly we can do.” (case no. 16, public hospital superintendent)

In the 50-bed hospital, there was no resident doctors and therefore, all indoor and emergency patients were attended by three emergency medical officers who took turns in each 8-hour shift.



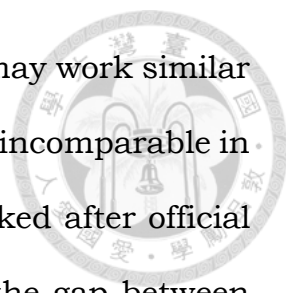
“In this 50-bedded (hospital) we have seated 100-bed hospital. Government gives us 100-bed medicine, supply and diet, but they are not giving manpower of 100 bed. We have not got manpower or infrastructure of 100 bed. Every day about 150 and above admitted patients stay in this hospital. Some patients are lying on the floor. When they come, we cannot keep them out, we have to treat.” (case no. 4, public hospital superintendent)

Health workforce

All that worked in public hospitals were full-time government employees. By seniority and responsibilities, there were outdoor medical officers, residential medical officer (RM), residential surgeon (RS), RS-obs/gyne, senior consultants, junior consultants, indoor medical officers. Within 6 and a half working hours each medical officer in the OPD had to see about 130-140 patients. After 2:30 pm until 8:00 am next morning, only the emergency department continued, but with limited number of doctors and supportive manpower.

Despite immense pressure for manpower, government hospitals could not recruit doctors on their own. The authority to recruit and designate doctors was with the Directorate General of Health Services (DGHS) for medical officers and Health Ministry for consultants. Recruitment is a lengthy process, leaving many posts vacant from 1.5 to 2.5 years.

On the other hand, private practice after office time among



government doctors was common. Government doctors may work similar or less hours in the private sector. But the two roles were incomparable in terms of salary and mentality. First, public doctors worked after official hours to fulfil their expected income level and narrow the gap between them and their peers in the private service. Their salary base was the lowest, compared with that of NGO-MFI and private hospitals. A superintendent in a district hospital disclosed a monthly salary of 38,000 taka, which included accommodation outside hospital premises.

“A consultant like me in a private clinic, every day income is 5,000 to 10,000 taka. 150,000 every month is the minimum, easily! Say, in Dhaka a doctor earns 10,000 to 19,000 per day as a professor.” (case no. 16, public hospital superintendent)

Some government doctors bluntly reported that they had private practice after official duties. A doctor with an MS or MD degree might receive 5,000 taka for a caesarean section in a private clinic. One sub-district level health officer (case no.7) disclosed a shocking performance record of 22 caesarean operations in a single evening. Second, the private practice has been justified with claims of longer working hours, public interest, constitutional (working) rights, and international standards.

“Public service in our country is 9 to 4 pm...we work 8 to 2:30, half hour difference (a day), they enjoy holidays on Friday and Saturday, but we enjoy only Friday.”

“In school, banks and other offices, they leave office at 4 pm, then they do what? Nothing until next day 9 am. But doctors go out, give service in private clinics, for his personal interest and for public interest.”

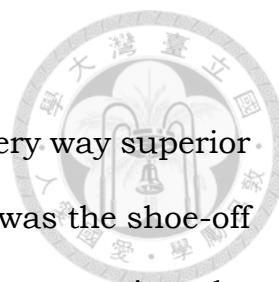
“We have the rights, constitutionally, that after the period of service we can give service to the people in private.”

“We are just doing according to ILO, if you demand out of office time, you have to pay. It is human service.”

(case no. 16, public hospital superintendent)

Out-of-pocket payment

Each patient paid a standard fee of 5 taka to see a medical officer, a medical school graduate with MBBS degree (non-specialist). Referral to specialists or admission could be made on need basis without additional charges. Medicine was free of cost, if prescribed. This nominal 5 taka could be easily waived when one cannot afford. Indoor patients did not need to pay for bed, diet or medicine if they used general bed. If they chose paying bed or cabin, they would be charged 2,000 taka per operation. They were subject to ambulance charge on the basis of 10 taka per kilometer, including return trip. This can also be supported by the social welfare fund when one was unable to pay.

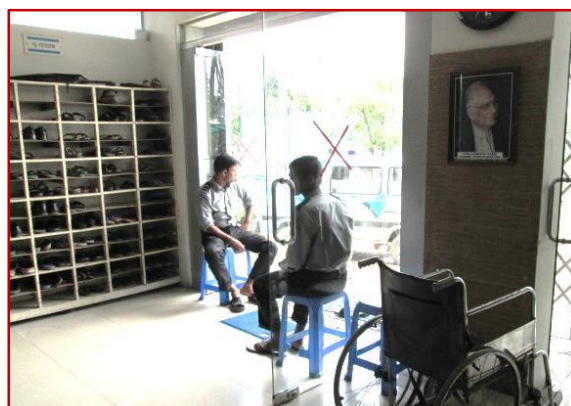


4.3.3 MFI hospitals

The physical environment of MFI hospitals was in every way superior to their public counterparts. The first striking difference was the shoe-off policy. Everyone was to remove sandals or shoes when passing the guarded entrance, place them on multi-layer shoe racks, before stepping onto the ceramic tile floors barefoot inside hospital buildings (photo below). This signaled hygiene. Among the healthcare facilities the author visited in Bangladesh, from private clinic, public, private and NGO hospitals, and even luxurious international-standard chain hospitals in the capital, it happened only in MFI hospitals. (see photos in Annex)



Shoe racks at the entrance of Hospital S



Shoe racks at the entrance of Hospital J

MFI hospital management took pride in their clean environment. Doctors in both Hospitals J and S boasted about the cleanliness. One noted,

“ (the hospital) is specially careful about cleaning, hospital is clean and clear. 14 cleaners work there, two on each floor, after one hour or half an hour, they wash the bathroom, floor, glass, table, ... most important

way to prevent infection.” (case no. 21, MFI hospital medical officer)

Inside the public hospitals, it was under-illuminated, simply or barely decorated, and crowded by poor-looking patients and their companions with no chairs to sit on. Lobbies in the MFI hospitals, on the contrary, were well decorated, lighted and furnished. Seats were usually available for waiting patients and families (see photos below). Overall, the environment in the MFI hospitals was more comfortable because it was less noisy, more orderly and looked cleaner. However, the shiny appearance also gave visitors or potential visitors that it might not a place for the poor. Beggars were not allowed to go near MFI hospitals, but they could freely gather by public hospitals.



Waiting area in a public hospital



Waiting area in an MFI hospital

MFI hospitals J and K hung a price list of their healthcare services in the lobbies. It looked like a poster-size catalogue of products. According to the author’s observation, few people stopped at the board to check the prices. Among patients that the author randomly enquired, the majority had no knowledge about the price until it was pointed out to them. Some

acknowledged they knew it and did not care. A couple of patients who learned about the cost of care for the first time were obviously surprised. In addition to highlighting transparency, the in-charge said that publishing fee schedule was meant to:

“encourage people to come to the medical market” and tackle “uncertainty” that prevented “patients from entering the medical market.”
(case no. 15)

These market-centered comments indicated that the fee disclosure was for patients to form a conclusion that the cost in MFI hospitals was below the market rate. This increased utilization, if buyers in the medical market compared prices between MFI and private hospitals, not between MFI and public ones, as entry fee in public hospitals was minimal or free.

Service delivery

Services hours were longer in MFI hospitals, which were 9 am to 3 pm (6 hours), 9 am to 4 pm (7 hours), and 9 am to 8 pm (11 hours). All had 24 hour emergency departments with at least one medical officer and other supportive workforce. In addition to resident medical officers, the most common specialists were gynecologists, pediatrician and orthopedics. According to the medical officers in hospitals K and S, they had about 30 patients a day and most of them were pregnant women who came for prenatal checkups. Around 80-90% of the patients in hospital K were non-borrowers. The largest hospital J that opened daily had about

70 patients each day, 71% were non-borrowers.

Outdoor consultation fee in hospital S was 200 taka for microfinance patients and 300 taka for non-member patients. This hospital of 50 bed had a 50% bed occupancy. On the day of interview, 10 of the 22 inpatients were caesarean cases. Except for outdoor consultation fee, no differentiation of other fees was made between borrowers and non-borrowers because the percentage of borrowers was negligible. Hospital J's bed occupancy rate was 70-80%, according to its director of health program. In hospitals K and J prices of services were displayed on a board by the entrance.

Patients said, in very short conversations with the researcher, that they used MFI hospitals because longer OPD hours enabled them to seek care in the late afternoon hours and they did not need to wait in long queues like in public hospitals. Another pointed out pleasant environment and helpful doctors made him bring his family here. MFI hospitals were attractive to some patients in at least four obvious ways. First, there was no chaos in MFI hospitals because fewer patients meant shorter waiting time and quieter atmosphere. Unlike patients in public hospitals, patients here always had chairs to sit on. Third, the shoe-off policy signaled that the place was hygienic, as mentioned earlier. Fourth, the hospital buildings had newer and more modern looks, externally and internally.

“in MFI hospital there are luxury facilities, if people who have more money, those who want to spend more they will prefer MFI hospital. But

the general people will come to Sadar (District) Hospital.” (case no. 1, chief administrative officer)



In addition to these obvious reasons, MFIs employed several strategies to increase utilization from the demand side. These strategies included (1) selling health packages (K); (2) sensitizing patients by paid community-based health workers (S, K, J); (3) issuance of health card to users (S, J).

Hospital K provided antenatal care (ANC) package for pregnant women at 100 taka throughout the duration of pregnancy until the point of delivery. The package came with 90 iron capsules, a delivery kit box and discounted laboratory facilities. For the example of ultrasonography, ANC cardholders paid a discounted 350 taka instead of 500 taka for regular visitors. According to the medical officer, this hospital had 70-80 new cardholders monthly, and up to 10% of them would receive caesarean sections.

The second strategy was incorporating community health workers. All the three MFIs had comprehensive networks in the community such as satellite clinics, traditional birth attendants (TBAs) and field-level health workers. Community health workers enjoyed high degree of trust in the village because they grew, lived, worked and provided service in the neighborhood. Respondent case no. 24 was found to be accompanied by a TBA who worked as community health provider. The elderly TBA described her work as:

“working door to door to collect patients from the village.” (case no. 23)

In exchange of her service, she and her family received free health care in the MFI hospital. Additionally, she would receive 100 taka as conveyance when she brought an outpatient case and 500 taka when she collected an operation case. She could bring with her 3-4 patients a day. The patient herself, after being left alone by the TBA upon researcher's request, validated the TBA's statement by saying that whenever she had health complaints, the TBA advised her to use MFI hospital and escorted her. In another MFI, paid community health workers reached out to all their beneficiaries (a common way to refer to microcredit borrowers or clients) and other community individuals by creating health awareness, managing common diseases, increasing coverage of health insurance, as well as sensitizing institution-based health care.

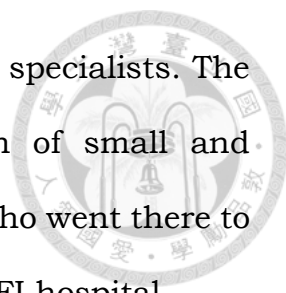
Issuance of health cards seemed to facilitate patient loyalty through a sense of entitlement. When the patient (case no. 24) was asked why she chose MFI instead of public hospital, the answer was that being a health card holder she was entitled to discounts at the point of service. Instead of 500 taka, she paid 400 to see a doctor from Dhaka. Note that to see a medical officer in the same hospital one only had to pay 200 (borrower) or 300 (non-borrower) taka. Doctors from the capital always had a great demand among patients everywhere in the country. She claimed that she never used public hospitals or private clinics. When there was a health need, she either went to a local pharmacy for minor problems or MFI hospital for more serious conditions. Hospital J also issued health card to

general individuals at the rate of 150 taka per year. Their own clients paid 350 taka per year which covered the entire family. Prices for the services came in 3 categories: cardholder, non-cardholder and staff. For example, a cardholding patient would pay 11,500 taka to receive a caesarean section while non-cardholding patient had to pay 12,500. In the case of normal delivery, it was 2,500 taka for cardholder and 3,000 taka for non-cardholder.

Health workforce: qualifications, multiple practices and employment patterns

On paper and on the signboard hung next to the entrance of MFI hospital K, there were 24 doctors of 4 different specialties. However, the chief medical doctor was the only one responsible for the 24-hour operation in the hospital. He himself was an anesthetist. Another junior medical officer who just completed internship joined recently. In case of operations, the superintendent depended on on-call doctors, especially gynecologists and surgeons. The following account was from the management in the MFI headquarter.

“If you hang (sign)board, you need to write so many doctors’ names. They (doctors) don’t come. If we need, if we call, then they come. Generally we don’t need. So many doctors but we don’t need all of them. Only surgeons come, only gyne doctors come, some orthopedics come for operation purposes. Only three. Purposes fulfilled. It is not possible for us to hire them.” (case no. 11, MFI board member)



Hospital S encountered a similar problem in finding specialists. The location where it operated had a high concentration of small and medium-sized private clinics. Not surprisingly, doctors who went there to provide medical care preferred private clinics over the MFI hospital.

“If we can manage specialist doctor like clinics, the number (of patients) will increase. But it is very tough, we invite some on Friday.” (case no. 13, MFI program director)

Despite taking full charge of the hospital K, the chief medical officer, who was a hospital employee, had full freedom to work in other health facilities at will. As in the public sector, multiple practicing was common, and might be even more liberal because MFIs were in no position to offer attractive salaries like the private clinics, and they also could not offer benefits or securities like the public sector. In the previous 8 months, three doctors came and left.

“We provide him (the chief medical officer) only TK40,000, but he is earning 4 lakhs (400,000). He spends 24 hours for the hospital...but somewhere, call comes, he can go. It is not possible to keep a doctor, ... he is also involved in other clinics, otherwise he will go, he will not stay here.” (case no. 11, MFI board member)

Hospital J did not seem to have manpower shortage, but they had different types of employment contracts with their physicians, basically on payroll or non-payroll basis. Payroll doctors were hospital employees who worked 7 hours a day. Medical officers with MBBS degree (medical

school graduate, non-specialist) received a monthly 25,000 taka based on 6 days a week, while consultants received 65,000 taka and senior consultants received 75,000-80,000 taka.



For non-payroll or part-time physicians, there were also different arrangements. One mode was fee for service. Physicians earned consultation fee at the rate of 300 taka per head, and the hospital earned from examinations like X-ray or ECG the consultant prescribed and from admitted patients. The other mode was lump sum payment, say 3,000 taka for 3 hours or 5 hours for chamber service or giving rounds. The idea was to achieve cost efficiency.

“I need doctors in the peak hour, not every time. I cannot employ unnecessary doctors. They come, make examination, make a round. In this way I can lessen the cost. Doctor is also happy, maybe he is working somewhere, coming for 2-3 hours, take some money and go.” (case no. 20, MFI hospital superintendent)

Financing: out-of-pocket payment

The MFI that established hospital J was the owner of 51% shares of a leading pharmaceutical company in Bangladesh. Handsome dividends came from the drug company every year as the main financing source of this MFI. By introducing business initiatives in the hospital management, hospital J had achieved cost recovery entirely on their own revenues three years after its birth. Cost containment and income generation were concerns of the MFI hospital management. The desktop computer of

Hospital J's health department director showed daily, weekly, and monthly earnings for him to assess cost recovery on any given day sitting in the office in Dhaka. On the day of interview, for instance, the fully digitalized system reported that his hospital had earned Taka 181,161 until 9 pm the previous day.

The flexible arrangement of doctors in MFI hospitals was not only to save the manpower cost, but was done in a way to utilize manpower most efficiently and maximize income. Payroll doctors attended the departments where more patients came. According to the respondent's estimation, 60% of the patients were seen by their own doctors and the remaining 40% by chamber practice doctors.

“If some department has very good doctor, even the payroll doctors get lots of patients, (in) some departments if they do not have very good doctor, then we cover by chamber doctors.” (case no. 20, MFI hospital superintendent)

In hospital K, the chief medical officer stated that monthly there were 30-50 operation cases, but he had to do at least 40 operations per month to sustain. For each operation of any health conditions they could profit 4,000 taka minimum. With the current amount it was barely manageable because there was income from ultrasound, laboratory facilities, ambulance rent, anesthesia charges and registration fees.

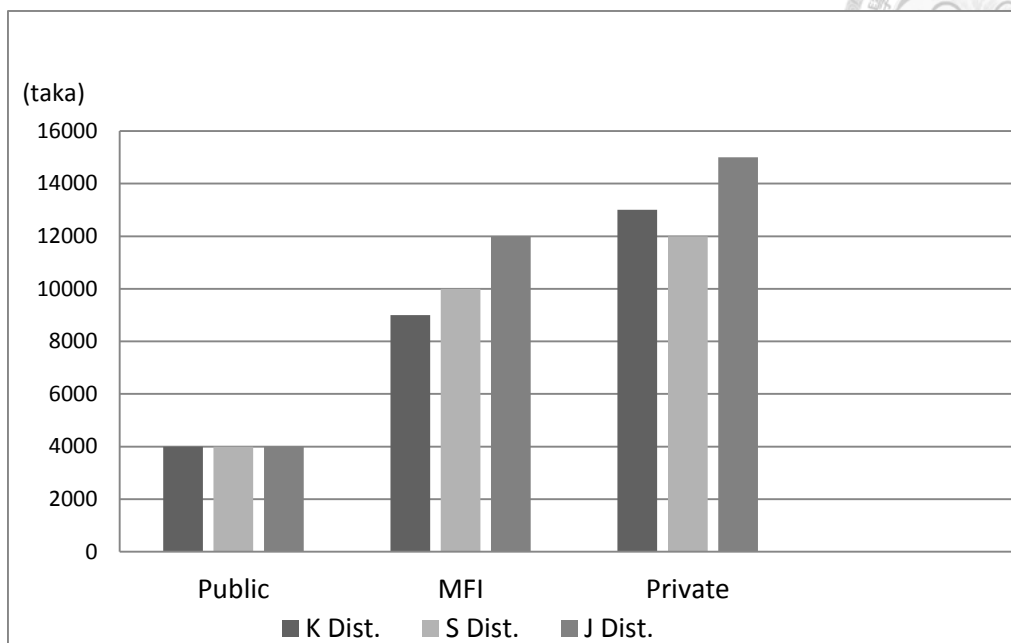
One MFI Hospital in-charge mentioned that the pricing scheme and health card were designs to help the poor people as well as the

community as a whole:

“Some people may sometimes feel that we are poor we cannot afford. So you buy the health card and get a discount for your health services. All groups are from the community but different groups. We have come to provide services to the community at affordable costs. People get the care and at the same time hospital should sustain.” (case no. 20, MFI hospital superintendent)

However, the cost was not really affordable in the views of the even non-poor patients. A respondent (case no. 25) that accompanied his wife expecting their first baby had no idea about how much he could pay. But when he learned the fee for a caesarean operation he told that if this method of delivery was indicated by the doctor he would have to borrow money from all possible sources because he had prepared only 5,000 taka, which could cover the cost of normal delivery but less than half the required amount in case of caesarean section. Figure 12 showed the charges of caesarean section in 3 MFI hospitals in comparison with private clinics and public hospitals. It was evident that charges in MFI hospitals charged slightly less than private clinics but had successfully created a niche in the market.

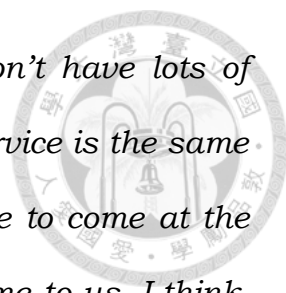
Figure 12. Fees for caesarean section by provider and district



Moreover, the patient (case no. 24) in another MFI hospital brought by a TBA had paid 400 taka to see a doctor. When left alone by her companion she complained that it was way too costly that she, and most of her neighbors could not afford.

“Maximum people are very much poor, they cannot go to NGO hospital, so maximum people will not get medical service if NGOs take the responsibility of this service.” (case no. 4, civil surgeon)

Another perception gap also existed among the microcredit borrowers. The medical officer acknowledged the tight financial constraints faced by the majority of microfinance borrowers, and pointed out that borrowers did not want to use MFI hospital until the last moment when the condition became difficult to handle. Delayed care seeking has been commonplace among the poor because they simply did not have the ability to pay.



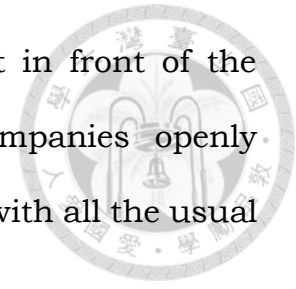
“Microcredit patients don’t have 300 taka. They don’t have lots of money to see a consultant. If they can be seen by me, service is the same and the fee is reduced...Microcredit patients usually love to come at the eleventh hour. When there is no way to go, then they come to us. I think, they think the cheapest rate will be more to them. But the payment is not mandatory to pay immediately, they can pay later. If they can’t pay, we will inform the microcredit branch to give us back our payment. But patients think no way without money...difficult microcredit borrowers! They did not have any ANC, didn’t do anything, they just came to hospital at the eleventh hour. Maybe there is a gap of information, maybe they are too burdened about their work or money...If they know they have not to spend any money during delivery, then they will come to hospital at first.”
(case no. 21, MFI hospital medical officer)

The above comment corresponded to the negative association between MFI hospital use and utilization of those from the poorest households, found in the questionnaire survey. The community health workers did not seem to approach the poorest and pass necessary information about their entitlements as beneficiaries of the MFI that ran a hospital to serve the community.

Health products

All the three MFI hospitals had attached pharmacies. In on MFI hospital, most of the items were post-operative drugs because of frequent operations. As a result, outpatients often needed to buy medicine from

private drug stores that lined both sides of the street in front of the hospital. Often, sales representatives from drug companies openly flocked in doctors' chambers to promote their products with all the usual incentives such as free samples, gifts or treats.



Health products, even not provided at the MFI hospitals, could be financed by MFIs and provided by microcredit borrowers. Medicine sale has been a popular loan activity among Grameen Bank microcredit borrowers. In 1998, medicine trade ranked 6th in the category of shop-keeping, for which 10,927 microcredit loans were disbursed, amounting to BDT 43,317,642 (or US\$1,082,941). In 2011, "medicine shop", as termed in Grameen's annual reports, was among the top 25 of all categories for which Grameen members took micro-enterprise² loans. Gender-wise, 6,432 females (ranking 25th among female borrowers) and 180 males (ranking 22nd among male borrowers) took loans totaling BDT 294,939,564 to run medicine shops.

One of the three MFIs in the study was linked with pharmaceutical industry. Not surprisingly, "medicine/pharmacy" ranked eighth in its top 10 loan use categories. Another MFI in the study, that had no known relationship with pharmaceutical industry and had not published their loan activities, also financed many medicine shop owners. During an interview, the founder said,

² According to Bangladesh Microcredit Regulatory Authority, general microcredit loans are for small-scale self-employment based activities. A loan size within BDT 50,000 is generally considered as microcredit; loans above this amount are considered as microenterprise loans, which are not intended as start-up capital.

“We have many (medicine shops). Just now I cannot say how many, but many are running medicine shops. Many people take 5 lakhs, 10 lakhs from us and run medicine shops.” (case no. 14, MFI management)

The author visited one medicine shop financed by that MFI. The shop owner had a borrowing history with the same MFI for 15 years and seemed to run well. Over the years he had expanded his capital to 2,200,000 taka from the initial 100,000 taka. He had an outstanding loan of 50,000 taka at the time of research. According to the shop owner, many of his clients were beneficiaries of the MFI from which he borrowed. Most of the drug stores in Bangladesh were unlicensed and run by unqualified people (Ahmed, Hossain, RajaChowdhury, & Bhuiya, 2011), probably including this one. (see photos in Annex)



Close look at medicine shop



Distant look at the shop

Another borrower with a BA degree in undisclosed discipline borrowed from this MFI 19 years ago and opened a diagnostic center. Years later it turned into the current clinic employing 4 surgeons, 1 orthopedics, 2 gynecologists, 1 pathologists, 2 ultrasound specialists and 1 technician for ECG and X-ray. He had 16 permanent staff, and all

doctors were part-time. His clinic charged between 8,000 and 10,000 taka for a caesarean section and 4,000 taka for normal delivery.

A different but common story: one MFI hospital in-charge expressed a sense of resentment and anger because of considerable internal pressure to purchase medicine from particular pharmaceutical companies. His decision of procurement and even prescription was often made not by profession but by persuasion. The source of pressure came from a close relation of the MFI founder.

“He called me, ‘please take this medicine, please purchase, prescribe this medicine’...I am the doctor, I know which drugs should be better...(but) they are pushing purchasing, pushing prescribing, to purchase medicine from the company.” (case no. 18, MFI hospital superintendent)

4.3.4 Major differences between MFI and public hospitals

Differences can be noted in separate sections describing public and MFI hospitals. They included number of patients, qualifications of health providers, cost, and employment conditions. Nonetheless, it is worthy to highlight one particular difference here: selection of patients.

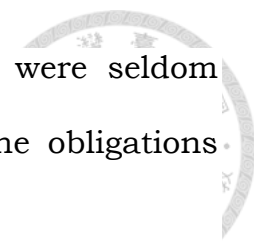
A public sector provider suggested this repeatedly, and in various ways:

“NGOs usually take the outdoor service, and uncomplicated patients, also (uncomplicated) indoor patients, simple operation, whenever complicated patient, they refer to government hospital....We face complications, they avoid complications. This is the difference.”

“NGO and private clinics don’t treat complication cases to take up and maintain their reputation.” (case no. 17, public hospital staff)

Avoiding complicated cases may well be true, but perhaps there is more at stake than maintaining reputation, as the following account showed:

“In the private sector it is difficult, we can’t handle patients like in the medical college hospital with...so much cautiously in here. In the medical college there may be a death rate in case of infant, or in case of patient like medicine or surgery patient, or gyne patient, there may be a death rate, but in here we don’t permit any death rate. That’s why we have to work so much cautiously....



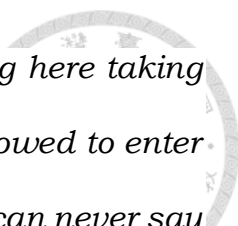
Avoiding death cases in Bangladesh where doctors were seldom threatened by malpractice litigation, the concern was the obligations MFIs had for their borrowers.

...here we have to work cautiously with microcredit patients. If we have accident with microcredit patient, the company will have to pay everything, so microcredit patient should be dealt with more cautiously...

...Last Thursday, a patient came with ruptured uterus, ... I can perform all the things. But this patient is microcredit borrower, then we referred to Dhaka Medical College Hospital by our ambulance. Ultimately the baby is lost, I think hysterectomy is also done.” (case no. 21, MFI hospital medical officer)

Patient selection in MFI hospitals could be policy-oriented rather than capacity-oriented. They could not claim their rights as MFI beneficiaries. On the other hand, the right to health care has been established and respected in the public hospitals even beyond their capacities or at the cost of compromised quality.

“In NGO hospital they have 50 bed, in private hospital they have 100 bed, they never allow more than 50 or 100 patients. Never ever. But in our public hospital, I have 100 bed but I have to accommodate unlimitedly, I cannot never say no. No. I will never say no, but they can say no. ... In proportion to that amount of bed they have enough staff, doctor, nurse, because they are doing some business. That is why the service of NGO hospital and private hospital is every way better than this public hospital.



But the drawback here is that patients are unlimited, coming here taking service free of cost, and we can never say you will not be allowed to enter this hospital because we have only 100 beds, it is filled up. I can never say this. Today I have 100 bed but there are more than 150 patients. If they come more I am bound to allow them, because this is a public hospital they have got the right to enter here...this is why the service of this hospital is a bit inferior to that hospital.” (case no. 17, public hospital staff)

4.3.5 Implications of MFI providing hospital care

Different interpretations of complementarity with identical rivalry

The first idea expressed by a couple of government officials was that provision of healthcare by NGOs or NGO-MFIs helped share heavy load from the public sector and was complementary. One local administrative chief took a proactive attitude. He not only appreciated MFI hospitals to share the pressure from public hospitals, but personally connected them with the Directorate General of Health Services. He welcomed more to come, adding that if any other wanted to run hospitals he would try to connect them.

“If MFIs have their own facilities, they will take some of the pressure off. So it will be good for them...I think it is a complementary kind of work.”

“There is a rush in 250-bed hospital, so patients go to private or NGO hospitals.”

“NGOs are helping with their manpower.” (case no. 2, district chief administrator)

The second type of idea viewed NGOs/NGO-MFIs as partners in the primary level and national prevention programs, doing public health rather than clinical services.

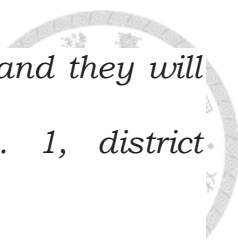
“You can imagine how it is possible for (government) Health Assistants to prevent disease to large number of population... there is

insufficient manpower. NGO will contribute and they work in the field level to bring the mass population for prevention.” (case no. 6, civil surgeon)

“NGOs are an inseparable part of the national health system. I don’t think govt is sufficient enough to take care of public health without NGO contribution. So if the NGOs work properly with the government then the health system will be strengthened...they will help us in the national programs, they will help us in the EPI (Extended Program on Immunization) programs, other research programs, we also help them, we also beside them to give them services by our workers, by our medicines, by our facilities.” (case no. 7, local health official)

Third, a slightly different but interesting argument framed MFI’s health provision as a temporary solution to fill in the existing gap by one local government officer and university professor. Acknowledging the transitional contribution of MFI health services, the public sector respondent warned that non-governmental intervention should not be regularized in the long run.

“In the interim case or transitional period, when government infrastructure is not built up, or government machine is not fully functional, then for the interim period there should be some intervention from the MFIs, some MFI health services may be introduced. Because if it is done in a permanent structure, then the same scenario will arise: doctors from Mymensingh, doctors from Dhaka, employed by government will come here one day per week or half day per week, and they will take



government money or donor's money and people's money, and they will get more money and render little service.” (case no. 1, district administrative head)

The fourth view, presented by MFIs themselves, about non-governmental sector complementing governmental sector, was quite different. One respondent clearly differentiated the target populations for public and MFI care.

“We add value to the government that the middle class people who can afford, we can absorb. You (government) give treatment to the poor people. Government system we want the poor who have more right. And other sector, let us run the sector. That is the public private partnership should be like. Always public and private should be together. It is complementing each other.” (case no. 20, MFI hospital superintendent)

Obvious rivalry coexisted with the complementary relationship between the public and MFI respondents. Instead of acknowledging the complementary role, the two parties totally discredited each other. While discussing reduced maternal mortality, an MFI executive claimed that,

“Our PM was honored prize in New York that we are doing good work in maternal mortality. In this side, maximum work is MFIs, but government never remembers our name or anything, ... ignoring contribution of MFIs. In maximum cases, especially in rural area, it's the contribution of MFIs. We are working for development of nutrition, we are working to eliminate anemia, specially pregnant mothers, ANC, PNC, we are doing both

preventive and curative.” (case no. 14, MFI management)

On the same issue, the health ministry official contested by saying that,

“By the NGO it is not possible that this indicator can be achieved because it is pocket-pocket thing. So how can they influence the national indicators? That is only maybe improved by the public facilities, that upazila (sub-district) health center, union health center, community clinics, these facilities changed the indicators. I think weakness is in the government system, maybe we have weaknesses in the international connections, maybe we have weakness in the website development and in other places but there is strong performance at the grassroots level. Otherwise how can they (NGOs) change the indicators, like maternal mortality, child mortality, TB patients improvement, identification of TB cases, everything is improving.” (case no. 10, health official)



A successful demonstration of privatized health system

Wearing a social hat, MFI hospitals justified themselves by charging slightly less than the private sector. On one hand they tried to undermine public hospitals, but on the other hand they adopted strategies including sending out community-based agents to collect patients from the countryside and displaying fees for each service item, as previously described in section 4.3.3, which indicated that they were actually competing with private providers.

“To encourage people to come to the medical market, first we publicize the fee schedule, and second the price must be less than the market. If you look at the waiting time, and under-table fee, people find our fee more competitive, than the rest of the market.” (case no. 15, MFI management)

Highlighting the public sector problems such as manpower shortage, misappropriation of resources and management, one MFI respondent offered a solution by proposing to privatize the health system, applying the business strategies,

“health system, public hospital management, you have to privatize. Well-management is in private (sector), because there is hire and there is fire. If you go to Dhaka Medical College Hospital, you feel that 40% or 50% of the people are not needed, but there is a lot of staff...I can reduce expenditure to half and add 15-20% profit...just give us one (public) hospital, let us show what we can do...government should come up, it should be a business model.” (case no. 20, MFI hospital superintendent)

A scholar viewed the privatization course of MFIs in the global context as the second wave of liberalization after the 1980s,

“After the advent of neoliberalism in the 1980s, ... it was designed by those power centers to reduce the state, to liberalize the financial sector. As part of the design they tried to shift the duties of state to the shoulder of NGOs. This is why initially they subsidized NGOs. When they (NGOs) have become self-sufficient, they (liberalization powers) are withdrawing their help and telling them: keep it in the market and run it in the market...they have succeeded in the first round by shifting some areas of state functions to NGOs, now it will be second time successful if NGOs become private sector.” (case 27, academic)

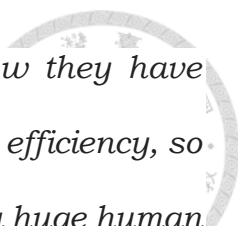
4.3.6 Leadership and governance

Chairs from two authorities that govern MFIs and provide policies to them had views that were almost contradictory to each other. Regarding the social programs, what MFIs can do and should do, there seemed to be little consensus among the major players, the apex MFI body, the microcredit regulatory body, and the practitioners.

Going commercial: debatable vs. absolutely no way

The interviewee representing MRA the regulatory agency noted that it did not regulate but would rather play a facilitating role in encouraging MFIs to start their own programs in health, education, environment, etc., which he termed 'credit-plus' mode. 'Credit-plus' basically means incorporation of social components like health and education into the micro-financing services. From an economist point of view, he expressed a positive opinion regarding MFI's healthcare provision in a commercial manner.

“Because they are organized, they can give the services better...they can (go commercial), if they want to give services to non-borrowers. They are most welcome. There is no restriction from us. But the problem is that the income they earn have to return to the members. ...If you don't allow them to expand, their hospitals will not run. With small money they cannot run a good hospital unless you also allow them to become commercial.”
(case no. 8, central governing body)



“Before, borrowers used to have only two choices, now they have something else, MFI clinics or hospitals. ...Competition brings efficiency, so if there is a competition there is nothing wrong in it. There is a huge human resources, if they can develop that human resources, there is no problem.”
(case no. 8, central governing body)

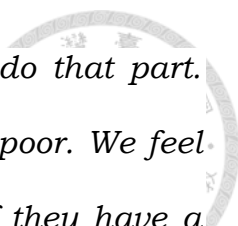
He admitted that there could be a danger if MFI hospitals go commercial, but concluded that it was an area to be debated,

“There is a danger if they go commercial...we need to talk about whether they need to remain small, to community services, rather than allowing them to become large hospital... if they drift out of social objectives, then they become difficult. We need to talk on this.” (case no. 8, central governing body)

However, the apex MFI body that provided seed capital to most of the MFIs in Bangladesh did not see things as positively. Drawing from the experience of working closely with MFIs, the chair made a strong point in disagreement by saying that MFI hospitals were business ventures, not service to the poor.

“MFIs are degenerating in all their activities, in terms of high rate of interest, not including the extreme poor. Similarly the health and other programs.” (case no. 9, apex financing body)

“Some applied for hospitals but we have not approved of any. Small scale health activities we allow, in the same area, not say in Dhaka or others, no way. We do not encourage setup of hospitals. But some do



defying, they take money from other sources. We cannot do that part. These are essentially business ventures, not service to the poor. We feel that they should use this money to help people directly, if they have a hospital, they argue that, 'we make profit from there, and we reinvest in the poor', this, we don't trust. We can't control that. So we don't allow that. We don't allow from our sources at all." (case no. 9, apex financing body)

Different interpretation of social investment

Regarding a clause which demanded 10% of MFI's surplus as input in social programs, policy makers and practitioners interpreted it in totally opposite direction.

The regulator interpreted 10% as a minimum requirement,

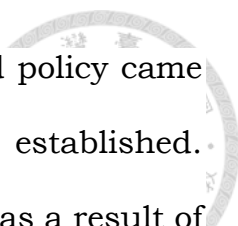
“They will spend 10% or more, we encourage to spend at least 10% on health and education. If they spend more we have no objection.” (case no. 9, apex financing body)

However, MFI practitioners interpreted it as a ceiling,

“It (PKSF) does not allow more than 10%. But 10% of the profit ... is nothing to start a health program. But PKSF should have a policy to provide some ... on the health programs, not only 10% will be sufficient to start a health program. Any strategy should clearly define what the loanee should do, what they should do, everything they should give.” (Case no. 20)

“There is a regulation, MRA's regulation gives you a ceiling, not more than 10% of the profit of microfinance can be used for the benefit of the beneficiaries, otherwise we would love to give more, but that detached us.” (case no. 15, MFI management)

The second case was MFIs' disagreement with the 'credit-plus' policy introduced by MRA. A respondent criticized that PKSF failed to offer a timely policy guidance when it was formed in 1990 as the first and sole



government-supported authority. They argued that delayed policy came too late as the MFIs' operation pattern had been firmly established. Instead of credit-plus, the current scenario was credit-only as a result of PKSF's inaction, so the blame should not be put on MFIs.

“MFI people don't believe in credit-plus, they want to earn, only credit they give. But PKSF the apex body, recently has taken the initiative, that includes health as important component, such big institution, why before two years, why not 20 years, you cannot blame MFIs because PKSF gives loan to MFI,...it is too late, it should have been added long before. Because it was written everywhere that microcredit alone cannot improve life of the poor people. This component was added, but how many MFIs have hard core poor? Why you do not do a mandatory system that whoever takes loan from you, they have to introduce health program? Or if needed, you invest in your own health program, you put your people to educate them, or to start them to do something.” (case no. 20)

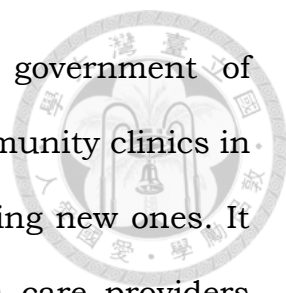
By this comment the MFI revealed four facts. First, the focus of this particular MFI and maybe others was earning. Second, MFIs had no interest in social cause and it was not easy to redirect them unless the authority made it mandatory. And third, MFIs did not serve hard-core poor, a frequent term to refer to the poorest. Above all, these problems stemmed from the governance of PKSF.

4.3.7 Community clinics – a field observation

While conducting quantitative and qualitative studies, one additional theme emerged as the researcher moved from one place to another and between different health settings. The one worth documenting was the government's efforts to revitalize community clinics all over rural Bangladesh.

During 1996-2001, the government of Bangladesh attempted to create community clinics in a population catchment of 6,000. Community clinics would become one more tier below the lowest level of the then rural health system to provide free-of-cost doorstep primary health care. The idea of community clinics came from the poli-clinico model in Cuba in 1960s. It was believed that, after meeting with Fidel Castro in the early 1970s, the Bengali nationalist leader also the first president of Bangladesh Sheikh Mujibur Rahman appreciated and was determined to set up community-based health services in a similar way. Unfortunately, Sheikh Mujibur was assassinated in 1975. It came close to materialize when his daughter became the country's prime minister in 1996 for the first time.

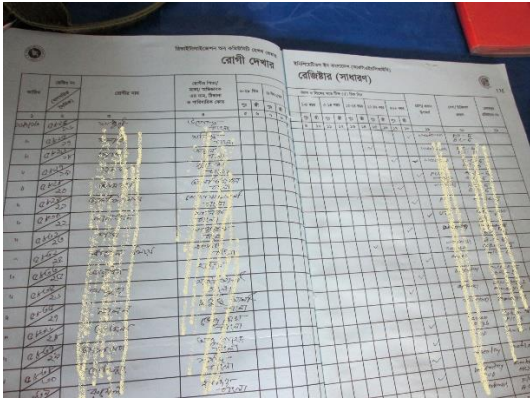
Due to change of government in 2001, all of the 10,723 community clinics were closed and remained uncared for 9 years. As a result, many were damaged or demolished for various reasons. Since 2009, with another shift of power, the ruling party started a 5-year project titled "Revitalization of Community Health Care Initiatives in Bangladesh (RCHCIB).



The mission of RCHCIB, fully financed by the government of Bangladesh, was to operationalize a total of 18,000 community clinics in all the 64 districts by repairing existing ones and creating new ones. It involved acquiring land, training of community health care providers (CHCP), procurement and distribution of 29 essential drugs, organizing local community groups and community support groups to operate/maintain/supervise the community clinics by themselves, and finally making rural population aware of and take advantage of such services. At the time of research, the project has accomplished 92% of its mission. Services provided from community clinics included maternal and neonatal health care services, normal delivery, integrated management of childhood illness, reproductive health and family planning services, immunization, acute respiratory infection, nutritional education and micronutrient supplementation, health and family planning education and counseling, identification of emergency and complicated cases with referral to higher facilities for better treatment, treatment of minor ailments and first aid of minor injuries, establishing effective referral linkage with higher facilities, etc.

The author visited 5 community clinics in two different districts. Three were notified and two were un-notified surprise visits. They were all functional and used by villagers. Visits of patients and their complaints were properly entered manually in the log books. Stocks of drugs appeared to be taken properly. There seemed to be enough supply of drugs when the researcher asked to see the medicine storage. One visit

took place past 2 pm, and the log had 26 entries. (see photos below)



At one community clinic, a log book documents date, patient name, complaints and drugs dispensed



Patients consulted community health care provider at one community clinic

Two un-notified visits were made with the company of an MFI health-in-charge, after completing the interview. The gentleman strongly challenged that community clinics were closed for many years and could never be revitalized. To prove his argument and to prove the Dhaka-based health official wrong, the author went with him to make two surprise visits. The first one was open and running, and so was the second, which stood in the even more remote woods (photo below).



The health official shared about villagers donating lands as a gesture

to support community clinics,

“...most of the lands are given by the common people, not the rich people, but the middle class people, low income group people because they remain in the village. They thought, if there is an institution they will be benefitted. The rich people don’t stay in the village.”

Among the donors was a freedom fighter in the liberation war,

“he has only 12 decimals of land, very small, and of that he gave us 5 decimals for building a community clinic, ..., I was not agreeing to take his land, ‘you have so small amount of land left with you, why should you give 5 decimal for the community clinic?’ He told me, ‘I am a freedom fighter, I fought for this country, and I want this country to be safe and everything, so I want to give this land for the betterment of my country.’ ” (case no. 10, health official)


Disagreement was expressed by MFI people and the health official. MFIs disregarded the revitalization efforts, and showed no confidence that the government could run them well,

“Similar types of clinics are established by NGOs or private persons, it will run more smoothly than government facilities.” (case no. 13, MFI management)

“They locked the door,... already rusted and destroyed. Until now, there is no improvement.” (case no. 14, MFI management)

On the other hand, a health official predicted that full implementation of community clinics would pose a threat to MFIs who profited unduly from working with the government in health programs

such as TB control.



“They (MFIs) are taking drugs from the government. After taking drugs free from the government, they give to the people with service charge. Anti-TB drugs they get free from the government. In the future our CHCP can give anti-TB drugs from our community clinics. So for them it is a very big challenge, then they will die. (One large MFI) has one or two microcredit areas and in those places they give medicine (freely provided by the government) and they are also taking service charge for the medicine. But community clinics in all rural Bangladesh give all 29 items free of cost. Not only that, the poor people, the poorest of the poor, when they are not capable enough to go to higher facilities, the community group helps them to take to higher facilities so they can get treatment rightly and get cured.”

(case no. 10, health official)

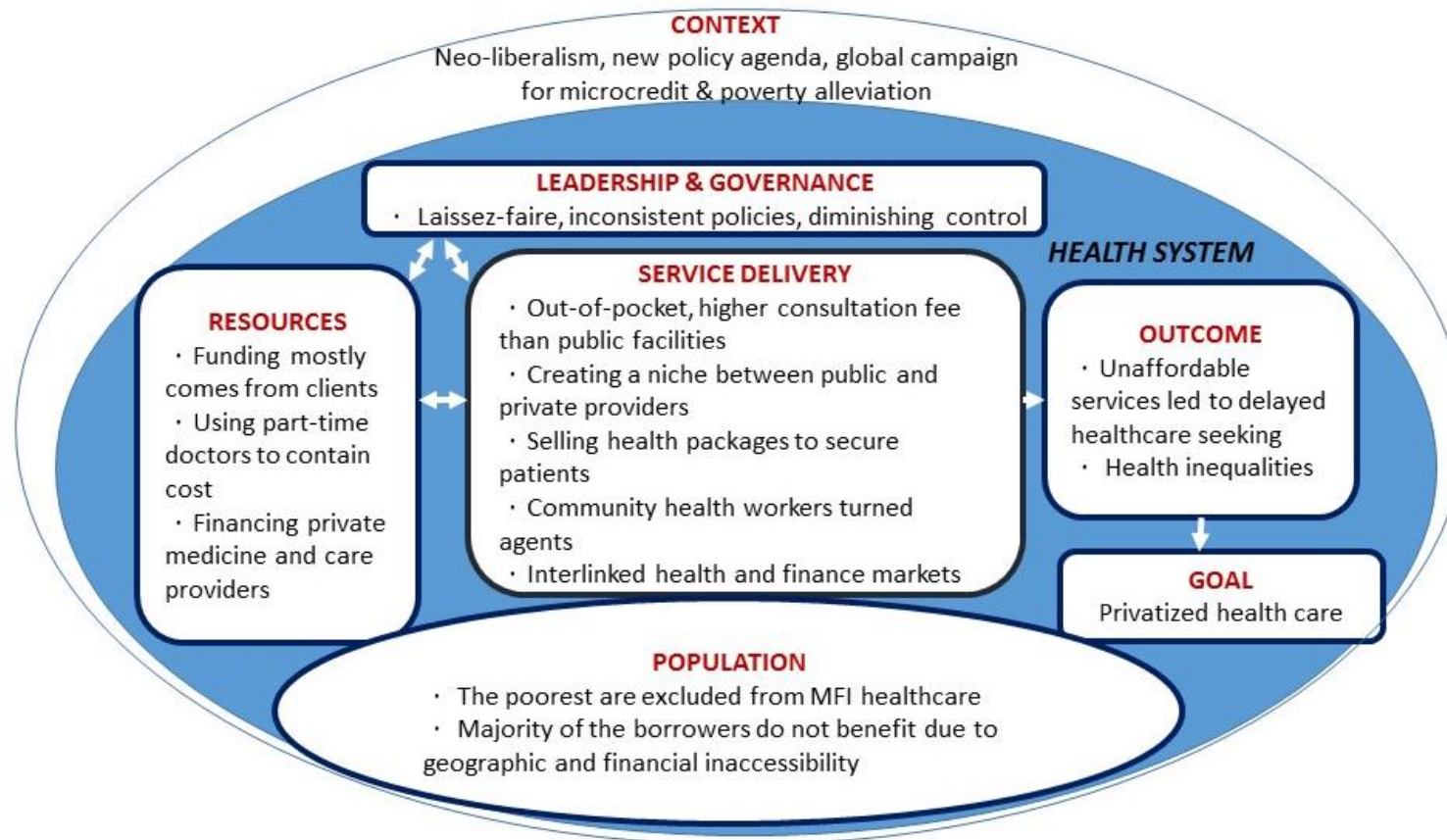
Chapter 5 Discussion




Integrating the results of quantitative and qualitative investigations, this chapter addresses 5 issues. First, how did MFIs miss the target population who are poor? It discusses the utilization gap in MFI hospitals by systematically excluding the poorest. Second, why did MFIs drift from their mission statement? Their mission drift was a reflection of drivers at organizational, national, global and philosophical levels which converged towards privatization. Third, the concept of interlinked markets was applied to suggest a mechanism behind health-seeking behaviors of microcredit borrowers. Fourth, who were MFIs accountable for? Growing financial independence of MFIs in relation to diminishing control of authorities seemed to help MFIs evade accountability. And finally, where will they go from here? Discussion in this chapter is based on microfinance-based health care system, as shown in the following diagram (Figure 13), mapped according to the research findings.



Figure 13. An illustration of microfinance-based health care system



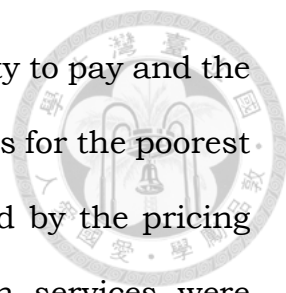
5.1 How was target population missed?



Evidence from the first part of this empirical study showed that, compared with outpatients in public settings, those in MFI hospitals tended to be younger, married, better educated, wealthier, seeking preventive care and spending more. After adjusting for known confounders, the poor-rich difference remained substantial. Unequal use of facility-based services by different economic classes has been noted in previous research (I. Anwar et al., 2008; Chowdhury et al., 2006; A. K. Halder, Saha, & Kabir, 2007; Hossain et al., 2012; Quayyum et al., 2013). However, inequity was more pronounced in MFI hospitals than public hospitals. It suggested that MFI hospitals missed their target population.

First and foremost, the consultation fees charged by MFI hospitals were significantly higher. As a result, poor patients were unable to afford a visit in MFI hospitals and less likely to use them. The finding was not unexpected. Previous research has noted that outside the public sector, not only private hospitals, healthcare facilities run by NGOs and MFIs also facilitated use-inequality by high service charge (N. Ahmed et al., 2006; Amin et al., 2010; I. Anwar et al., 2008; Griffiths & Stephenson, 2001). In poor people's own words, the NGO healthcare was meant for the rich (N. Ahmed et al., 2006). This opinion coincided with the patient profile mapped by this research.

Income disparities played the greatest role in the unequal use of MFI hospitals. This research reiterated the fact that financial constraint is a major barrier for the poorest to use health services (Ahmed, Tomson,




Petzold, & Kabir, 2005; Ensor & Cooper, 2004). The ability to pay and the price of service are two sides of the same coin. The choices for the poorest segment of the population were systematically restricted by the pricing schemes of MFI hospitals. Studies showed that when services were provided free of charge, poor people visited NGO facilities more than public ones (A. Anwar et al., 2004; I. Anwar et al., 2008), which was probably due to advantages in the NGO sector, such as closer relationships, a strong reputation at the grassroots, motivated staff, and less chaos. However, when NGO-MFI hospitals charged patients at a much higher rate than public ones, fewer poor patients used them, as observed in the study.

User fees at MFI hospitals did not appear to be poor-friendly, which was echoed by the negative association between utilization and the poorest household income. The reasons of the negative association became evident in the in-depth interviews. As discussed earlier, affordability played a decisive role in patients' choice making. When one medical officer in an MFI hospital complained about some microcredit patients who delayed seeking health care, it was an indication of a financial barrier (Killewo et al., 2006; Rutebemberwa et al., 2009). Secondly, while all the three MFIs mobilized their community workers or TBAs to sensitize their microcredit clients to use their hospitals, these "agents" who knew the fee structure were unlikely to indiscriminately pursue needy patients but financially able ones.

Another aspect involved geographic accessibility of services. MIFs

operated hospitals in town, far away from the majority of borrowers who lived and worked in rural areas. They were less inclined to pay for more expensive services. Moreover, the cost of traveling and wages lost might also play into their decision as to which care provider to go to. Hospital care made available by MFIs did not seem to significantly increase accessibility among the poorest, whether they were microcredit borrowers or not. Like in the credit programs, the poorest were excluded.

5.2 Why was target population missed?



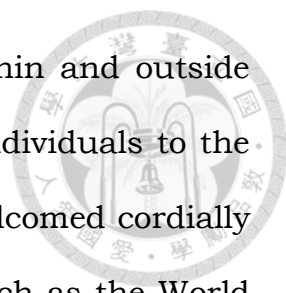
Similar to the exclusion of the poorest from credit programs, a tendency to marginalize the poorest patients from hospital services was noted in this study. At the organizational level, the reason for the former was to reduce the risk of bad debt (Montgomery, 1996; Simanowitz, 2002) and the underlying cause could be the same for both credit and social programs. Researchers summed it up as a trade-off between financial sustainability and outreach to the poor (Cull & Morduch, 2007). Establishment of a secondary hospital and care provision are costly investment, therefore to maintain hospital operations the managers need to take a business approach such as reducing risks and cost, increasing revenue, improving productivity, and enhancing utilization (Kaplan & Norton, 1996). Providing preventive care for a higher fee in urban areas and targeting healthier patients of higher socioeconomic status with a sense to invest in health well fulfilled these goals. In the current study, not only did MFI hospital patients report better health, they also reported higher levels of household income and need for preventive care, a similar phenomenon noted in developed societies (Katz & Hofer, 1994; Sambamoorthi & McAlpine, 2003). As healthcare evolved towards a business model and the provision of care became dependent upon a patient's ability to pay, the poorest were naturally and further marginalized. Ahmed and colleagues expressed the same concern by noting that if NGOs relied on cost recovery through user-fees they would inevitably stray from the goal of service to the poor (N. Ahmed et al.,

2006).

Local NGOs heavily relied on foreign aid in the early days. The emergence of microcredit provided them with the scope to pursue self-reliance and independence from donors (Ahmad, 2003). Concentration on growth and scaling up resulted in an agenda shift from “*development of others to development of selves*” (Ebdon, 1995). Since the majority of NGOs turned NGO-MFIs, they prioritized microcredit at the expense of other activities such as organizing the poor, demanding social protection, advocacy, empowerment, primary health care, education and so on (曾育慧 & 鄭雅文, 2011).

In the national context, government in general accommodated NGOs by allowing them to participate in development work of various sectors, even during the authoritarian regime in the 1980s. But specifically, the pro-liberalization Bangladesh Nationalist Party (BNP) administration (1991-1996 and 2001-2006) initiated a landmark process of economic liberalization in the early 1990s. It coincided with the growth of NGO-MFIs striving to create a bottom-up economy with the poor. A noteworthy characteristics of MFIs in Bangladesh was their ever-increasing volume of clients, on whom MFIs might exercise certain political influence. As a result, different forms of collaboration and partnerships between the governmental and non-governmental sectors fueled the NGO-MFI industry in the country.

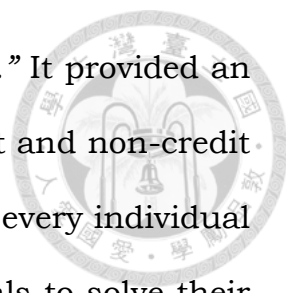
At the global level, the Grameen Bank model of poverty alleviation



was internationally accepted and widely replicated within and outside Bangladesh. The philosophy of this model – bringing individuals to the market with minimal government intervention – was welcomed cordially by institutions and donors advocating neoliberalism such as the World Bank. The Bank suggested NGO-MFIs to integrate with commercial financial markets, encouraged large NGOs to establish themselves as banks, and supported wholesaling credit to established NGOs and use smaller NGOs as brokers, etc., guiding them towards the maturity of financial institutes (World Bank, 1996).

As one respondent warned, after the first round of liberalization that successfully shifted some functions of the state to NGOs, the second phase mission was to privatize the NGO sector, which seemed to be working right now. MFIs not only needed less and less support from PKSF, they also got almost free from foreign fund. As of June 2013, foreign aid only had a meager 2.5% out of their total funding. MFIs have learned how to maneuver market instruments such as dealing with commercial banks or giving term loans. Paradoxically, the mission to help the poor and the poorest in the evolution of NGO-MFIs has been drifted, partially inevitably and partially intentionally.

The paradox, or the collision between mission statement and reality, came from the coherence with neo-liberal philosophy rooted in microcredit. The book *“Banker to the Poor”* is a manifesto where Yunus envisioned the future healthcare provision, *“The state would not be required to provide free or subsidized healthcare or schooling. An*



entrepreneur could run a health-care service for the poor.” It provided an explanation why MFIs ran and have been running credit and non-credit (social) programs the business way. Microcredit regards every individual as a potential entrepreneur and expects these individuals to solve their own problems, including poverty, health and education, by participating in business activities. By promoting social entrepreneurship, advocates minimize the role of the state and ignores the structural drivers at the societal level that form the socioeconomic scenario, such as infrastructure, resources redistribution mechanism, safety net, and power relationships between groups. Social entrepreneurship is insufficient for structural transformation and poverty alleviation. The African experience found that it could undermine support for state-led development and democratic reforms. Researchers concluded that social entrepreneurship contributed in small ways to development (Nega & Schneider, 2014).

By promoting “right to credit”, advocates and practitioners tried to undermine the crucial means like health and education that enhance the ability of individuals to develop themselves, not only against the fact that both have long been acknowledged as basic human rights, but sabotaging the global efforts to realize these rights.

The eroding effect is reflected in the largest MFI in Bangladesh, ASA. This MFI underwent a major transition to solely focus on microfinance from other programs in health and nutrition, education, sanitation, etc. Apparently, the policy shift facilitated their growth in scale to become the

largest MFI in the country. This model probably encouraged many other NGO-MFIs to stick to their “credit-only” practice as one respondent pointed out. They are moving ahead on the road to a privatization, as prescribed by Yunus and the World Bank. For those who provided hospital care in addition to credit services, they followed the same prescription and created a new market, which is to be discussed next.

5.3 Credit and health care – an unequal linkage



The third hypothesis that MFI hospitals were used more by microcredit borrowers has been proved. The finding was consistent with existing literature in which microcredit membership was associated with an array of positive outcomes, i.e. service utilization (Amin et al., 2010; Amin et al., 2001), health behaviors (Begum, Moneesha, & Sayem, 2013; Kamal & Islam, 2010) and maternal knowledge (Hadi, 2002). In addition, length of participation in credit programs exhibited a significant impact on a woman's choice of provider. The dose-effect relationship was indicated in previous explorations between duration of membership and outcomes like poverty reduction or health knowledge (Berhane & Gardebroek, 2011; Hadi, 2001; Islam, 2011; Nawaz, 2010). Researchers and practitioners used the term integration or alignment to refer to activities combining credit and non-credit components (Leatherman, Metcalfe, Geissler, & Dunford, 2012; Saha, 2014). Some considered this a result of borrowers' enhanced capabilities over time (Mohindra & Haddad, 2005). Nevertheless, the gradient pattern of a combined effect of income and membership on utilization implied that membership effect was limited to moderately- and non-poor.

Why were microcredit borrowers more likely to use MFI hospitals? Willingness to pay for a relatively cozy environment, less waiting time, longer service hours, and probably closer relationship were obvious reasons. As MFI hospital users also found services too costly, the question remained: if government hospital and MFI hospital stood side by

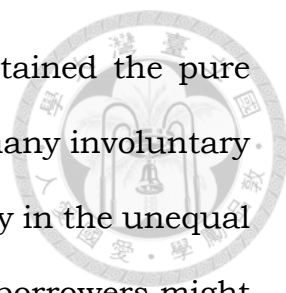
side, what mechanism diverted microcredit borrowers from government facilities that had more specialists and senior consultants, and charged close to nothing?



In an attempt to understand the possible mechanism, the concept of interlinked markets might be applied to analyze the “medical market” created by MFIs. In his seminal research on agrarian economy and semi-feudalism in some east Indian villages during 1970, Amit Bhaduri presented a model of semi-feudalism with four features: sharecropping, perpetual indebtedness, landowner as the lender of consumption-loans, and peasants’ inaccessibility to market (Bhaduri, 1973).

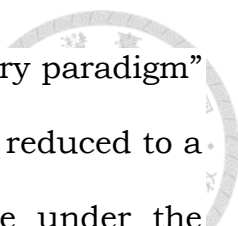
NGO-MFIs in today’s context dominated the rural life and established a new form of patron-client relationship (Ahmad, 2000; Karim, 2011). Even more influential than traditional landlords, they organized self-help groups, provided microcredit and micro-enterprise loans, enforced compulsory savings through lending, facilitated repeated borrowing, and offered health care, sometimes also education, and derived income from these activities. Traditional landlords in the semi-feudal society interlinked the capital and commodity markets by providing loans on one hand and determining prices of essential products on the other. Likewise, MFIs took control of the capital market and then linked their clients with a health market created outside the public and private sector, in the name of social services.

The problem arose because such provision of healthcare in the MFI sector was beyond control or regulation. The interlinkage made it difficult



to measure to which extent the health programs maintained the pure nature of social mission. It was also hard to know how many involuntary MFI hospital users there were, but being the weaker party in the unequal patron-client relationship, patients who were long-term borrowers might feel more obligated to accept the deal within their limits, regardless of their willingness. The borrowers from the poorest household had no way to afford costly services so they were the hardest to mobilize and might not be seen as lucrative clients after all. The network of MFI community health workers has long been working as health products salespeople (Ahmed, 2008; Khan, Chowdhury, Karim, & Barua, 1998). Even in the sense of market economy, this market transaction seemed to disfavor the less powerful. In the views of Amit Bhaduri the economist, interlinking markets led to “forced commerce,” a form of exploitation (Bhaduri, 1986).


From public health perspective, the interlinkage fueled commercialization and commoditization of health care at the cost of people’s entitlements. Such relationship was considered exploitative because the transaction took place not between buyer and seller but between patron and client. And it was also disempowering. In the long run, there may be a risk when the loss of entitlements is taken for granted. By maintaining the patron-client relationship, the NGO-MFIs that embarked on commoditization process of health care might have instilled the same idea into the mind of microcredit members and users of their services. NGOs used to organize people at the grassroots to demand social protection from the state (Kamat, 2004). But the “social



mobilization paradigm” was first replaced by “service delivery paradigm” (S. Rahman, 2006), and then the scope of service has been reduced to a few profitable services, as observed in the study. Those under the influence of NGOs and habituated to purchase services from the marketplace probably no longer believe, or are unaware, that they are entitled to public services such as health care. Foregoing the role of social organizer, NGOs that wear the hat of social entrepreneurs might bring negative impact on empowerment, poverty eradication and participation in public affairs (S. Rahman, 2006). Future researchers are suggested to investigate the opinions of microcredit members about the provision of health care.

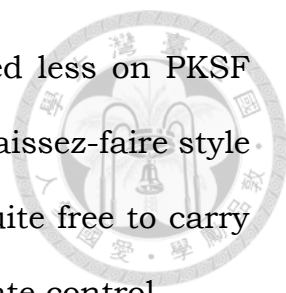
Some may argue that providing some service is better than providing no service, i.e. providing credit/healthcare to some people is better than providing no credit/healthcare. Following the same logic, segmentation of patient may not be looked at in a negative way because when well-to-do patients receive care from private or MFI sector, the poor can use public hospitals without having to compete for limited resources with the non-poor. The point of debate is whether the resourceful group enjoys first and the vulnerable waits last is fair and just when it comes to health services. States that made health services public made a choice. The vested interest group never lets go off their privilege unless a redistribution system is in place. Justice and fairness does not happen naturally, but inequality does when privatization is left to form an order.

5.4 Governance and accountability



Two governing bodies, MRA and PKSF seemed concerned about interlinkage, though they may not use this term. But so far neither has come up with effective strategies to address the issue. Not only did these two agencies voice contradictory views towards MFIs' hospital programs, conflicts between words and behaviors also existed within each respective agency. Prior to the interview with the head of MRA, the agency issued a circular regarding non-credit operations. It demanded that MFIs receive approval from MRA before using surplus for services/activities outside the microcredit purview. Despite the directive, the MRA chief explicitly waived the regulation and welcomed MFI's involvement in any form of health programs during the interview. MRA has been dedicated to addressing the pressing issue of multiple borrowing but with regards to non-credit activities, there is still a long way to go to implement adequate regulation and transparency requirement.

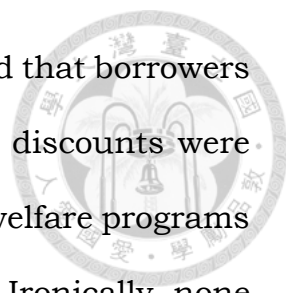
Contrary to the views of MRA chief, the chair of PKSF expressed strong objection against MFIs' application for or operating hospitals by calling such projects "business ventures." Nonetheless, all the three MFIs in the study continued to receive capital from PKSF as its partner organizations. The influence of PKSF on MFIs was declining. In the 1990s it was mandatory that MFIs collect foreign funds through PKSF, which was able to exercise financial control on behalf of the government. As MFIs matured, they have secured alternative financing channels such as commercial banks (15% of MFIs funding), ever-increasing clients' savings



(33%) as well as their own surplus (30%) and depended less on PKSF (12%) (Haque, 2002; MRA, 2014). Under the somewhat laissez-faire style leadership and diminished governance, MFIs seemed quite free to carry out two modes of operation simultaneously with little state control.


Despite inconsistent positions, the two governing agencies asserted one principle: profits earned by MFIs must be returned or shared by their clients. It was never clear how the principle could be translated into practice, so PKSF straightforwardly dismissed the possibility that profit-driven MFIs could run any genuine social business. As mentioned in the previous paragraph, the largest share of their funding came from savings of their own clients, which increased from 29% in 2009 to 33% in 2013, and cumulative surplus rose from 26% to 30%. One of the three MFIs in the study disclosed that about 29% of their fund came from clients' savings, which was a little lower than but still close to the national statistics.

Two lessons can be learned from these two indices (clients' savings and cumulative surplus). First, MFIs were growing financially sustainable and second, MFIs were thriving on the collective input of their poor borrowers, even if not the poorest, whose money also supported MFIs' health programs. In this sense, microcredit clients were the major patrons of MFIs. If MFI hospitals were run as for-profit businesses, then clients of MFIs must be entitled reasonable shares, as heads of MRA and PKSF argued. If MFI hospitals were members' welfare program, then MFI clients must enjoy more privileges than what were



currently available. Findings from this research suggested that borrowers occupied a small portion of their total patients and the discounts were either trivial or nonexistent. If MFI hospitals were social welfare programs for the public, then friendlier policies should be in place. Ironically, none of the scenarios matched the existing pattern. Since the governing bodies at the top lacked concerted or feasible regulatory measures about MFIs running hospitals, and the clients at the bottom were in the dark, it remained unclear for whom MFI health programs were accountable.

5.5 Community clinics, how do MFIs cope?



The discussion on the recent mushrooming of community clinics all over rural Bangladesh is brought up to highlight two contrasts. First, while NGOs moved up to providing secondary care, the public sector introduced an even-lower setup that reached down to the grassroots; second, while NGOs detached from social mobilization, community clinics systematically organized villagers into “community groups” and “community support groups” to manage their health affairs.

Functional community clinics all over rural Bangladesh appeared to be an encouraging development in recent years. The fact that the majority of patients in Bangladesh seek primary level services underlines the importance of strengthening primary health care. As the lowest level in the public health system, community clinics constitute a newly established network of primary health care, open 6 days a week and free of charge. While most of the MFI people were skeptical, and whether revitalization of community clinics was politically motivated, the sight that community clinics were open and staffed and used by villagers could not go unnoticed. So long as they continue regular services and coordinate well with referral facilities, the villagers would gradually realize that they are entitled to affordable healthcare. They might also less likely seek expensive private or MFI services by spending half day traveling long distance and losing half-day income. Community clinics might create a ripple effect in three areas: providing health services, increasing awareness and most importantly, empowering villagers. They

lay a good foundation for further efforts towards universal coverage.

Whether MFIs like it or not, they would play the role of critics, monitors or collaborators/partners. NGOs had worked as partners of the government development programs before they turned credit-only MFIs. On one hand, MFIs can have their field workers join in the efforts to encourage communities to take advantage of these clinics and sensitize them to play an active role to ensure smooth functioning of the clinics. On the other hand, NGO-MFIs could reorganize and refocus their health programs at the primary level and pick up an intimate relationship with beneficiaries, rather than just maintaining a credit-oriented or commodity-oriented relationship (Ahmad, 2003). There should be other innovative ways for NGO-MFIs to interact with community clinics.

However, it depends on how NGO-MFIs position themselves in perspective and where they would like to go from here, as NGO-MFIs nowadays are no longer NGOs decades ago. They might develop to be formal financial institutions, opt out of non-financial work and become full-fledged private companies. Whatever their next move is, the status quo should end, or it will not be fair for microcredit borrowers, non-borrowers, the poor and the poorest.

5.6 Limitation

A major limitation of this study is that it only assessed a few socio-demographic and economic correlates, as well as some hospital characteristics. It was not possible to exhaust all the factors at the individual and organizational levels. Quality of care undoubtedly mattered, but it was beyond the scope of this research.

The level of comparability might raise a concern. Although the two types of hospitals were located in town and providing secondary care, they varied greatly in other terms. Hospital size is one example. In the analytical statistics, hospital size was excluded due to a high degree of multicollinearity with hospital ownership. However, the justification to make the comparison was to test if the “care for the poor” mission declared by MFI hospitals was authentic versus “care for all” in public hospitals. The best indicator seemed to be user’s socioeconomic condition. Other measurements to assess hospital utilization such as quality of care or patient satisfaction could be considered in future research.

Thirdly, the simple measurement of income might be inaccurate. However, underreporting of household income in developing countries is commonplace (Anand & Segal, 2008; Ravallion, 2003; Székely & Hilgert, 1999) and seen as a systematic error and difficult to deal with. The underreporting of agricultural income in Bangladesh and elsewhere has been regarded as worse than any other sector. Nevertheless, the notion that underreporting by the rich is more prevalent than among the poor (Anand & Segal, 2008; Ravallion, 2003; Székely & Hilgert, 1999) has

given the author confidence that the gap identified in the present research would be even wider, if there was accurate income information.

Finally, the data were from a small sample in selected towns. Therefore, the findings pertained to the hospitals at the time of the interview.

Despite these limitations and the fact that MFI hospital services were limited in certain areas, this study may be the first to identify and gauge the magnitude of the socioeconomic divide in MFI hospital use. It highlighted the necessity to further evaluate the effectiveness of MFI hospital programs in reaching the poorest and its implications.

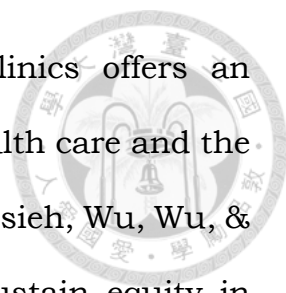
Chapter 6 Conclusion



This study examined whether the rich-poor gap was effectively narrowed in health care facilities established to provide care for the poorest. It found marked inequality in utilization, and income disparities contributed most. The poorest people, borrowers and non-borrowers alike, did not benefit much from MFI hospital initiatives. Presently the scale of MFI hospital service is limited and it is not easy to measure a significant effect on the health care system. However, the trend of MFIs' gradual engagement in profit-oriented hospital care deserves close attention from public health researchers and policy makers.

As health inequalities worsen in developing countries, the implications are profound. Participation in credit programs had different impacts on households of different socioeconomic situations. Mere availability of services does *not* guarantee equitable or affordable access. The limitations of using microcredit as a platform to deliver public goods or strengthen health systems have been illustrated in this research.

The author offers three suggestions. First, rather than operating hospitals in urban areas, MFIs may reorganize health programs around the principles of primary health care, namely, bringing affordable care as close as possible to where people live and work (WHO, 1978). MFIs have demonstrated great strength in community-based disease prevention and health promotion (El Arifeen et al., 2013; Quayyum et al., 2013) and this might be the areas where MFIs can better contribute to poverty reduction.

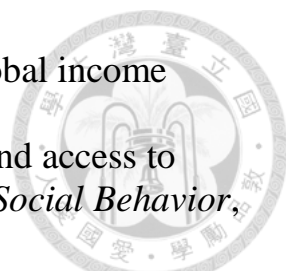


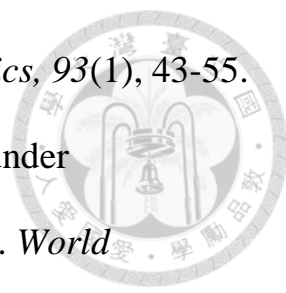
Working to strengthen publicly-funded community clinics offers an opportunity to start with. The importance of primary health care and the fair distribution of this care cannot be overemphasized (Hsieh, Wu, Wu, & Chiang, 2013; Starfield, Shi, & Macinko, 2005). To sustain equity in health care utilization and uplift the poorest, this would be a wise strategy. Second, Non-credit activities of MFIs should be transparent, separated and properly regulated. Third, regular monitoring and evaluation is important to recognize the degree to which the poor benefit from targeted programs. The policy-making processes require essential information from routine examinations as well as research. It would ensure that health and other development programs stay focused on the organization's mission. This holds true for policy makers in both government and NGO sectors. In the development, implementation and evaluation of health programs, concerned authorities and NGOs must always take note of the inequality gap and examine what component widens the gap and makes people more vulnerable. This is the key to holding MFIs accountable and responsive to all stakeholders.

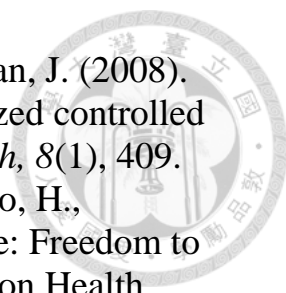
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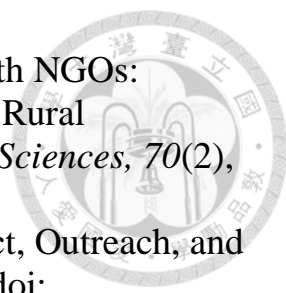


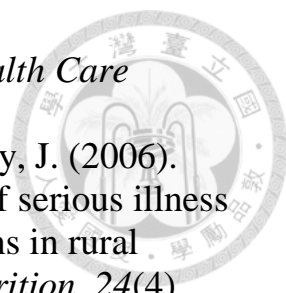
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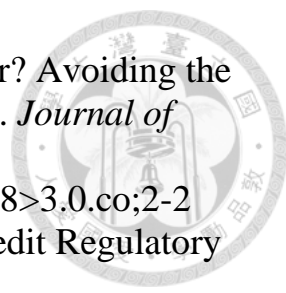
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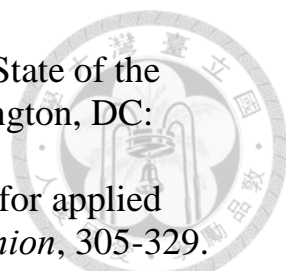
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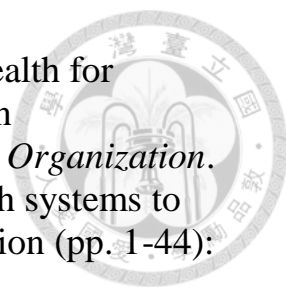
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Annex: Questionnaire



Health Behaviors and Attitude Study

Ref No: _____ Date: _____

Location: _____

Assalamuwaliakum, my name is _____ I am part of a research team in Taiwan. The research aims to understand health behaviors among people in Bangladesh. Information and opinion you provide is important to enhance the understanding. In this regard I would like to ask you some questions about your experience. It will take approximately 20 minutes to complete. Thank you.

Health

1. In general, would you say your health is:
 (1) Excellent (2) Very good (3) Good (4) Fair (5) Poor
2. Why do you come here? (1) preventive (health checkup, immunization) (2) acute conditions (fever, diarrhea, accident/injury) (3) chronic conditions (diabetics, hypertension, heart disease) (4) common cold (5) others, (if possible) specify conditions _____

Health Seeking Behavior

3. In the past 12 months, for what conditions did you (patient) see a doctor here and how many times?
 (1) Preventive (prenatal, neonatal, postnatal checks, immunization), times
 (2) Curative, acute (obstetric & gynecologic treatment, fever, diarrhea, accident/injury, cold), times
 (3) Curative, chronic (diabetics, hypertension, heart disease), times
 (4) Operation (surgery: eye, other parts), times
 (5) Others _____, times
4. In the past 12 months, have you had a cesarean delivery in this hospital? (1) Yes (2) No.
5. In the past 12 months, have you had a normal delivery in this hospital? (1) Yes (2) No.
6. Where do you most often go when you are sick? (choose only one answer)
 (1) government hospital/clinic (sadar or district hospital/MCWC/urban health center/FWC/community clinic/ diabetic center) (2) NGO hospital/clinic (3) private hospital/clinic (4) doctor's chamber (5) pharmacy (6) others (Kabiraj/spiritual healer/Ayurvedic practitioners/homeopathic practitioners/grocery store (7) DK.
(6-1) You go there because the price is affordable? (1) Yes (2) No.
(6-2) You go there because service is better? (1) Yes (2) No.
(6-3) You go there because someone recommended it? (1) Yes (go to Q6-4) (2) No (go to Q7).
(6-4) Who recommended? (1) family member (2) MFI staff (3) neighbor/friend (4) other, _____
7. Are you or anyone in your family a microcredit borrower? (1) Yes (2) No.
8. Did you go to any different place for treatment before you or your family became a microcredit borrower? (1) Yes (go to Q8-1) (2) No (go to Q9).
(8-1) Where did you most often go? (1) government hospital/clinic (sadar or district hospital/MCWC/urban health center/FWC/community clinic/ diabetic center) (2) NGO hospital/clinic (3) private hospital/clinic (4) doctor's chamber (5) pharmacy (6)

others (Kabiraj/spiritual healer/Ayurvedic practitioners/homeopathic practitioners/grocery store (7)Don't know.



Perceptions of Health Care Service

9. In general, you find government health facilities:
(1)Very good (2) Good (3) Fair (4) Poor (5) Very poor
10. In general, you find MFI health facilities:
(1)Very good (2) Good (3) Fair (4) Poor (5) Very poor

Attitude towards Health Service Provision

11. Do you agree that government should provide health services (including health care and drugs)?
(1) Strongly agree (2) Agree (3) Undecided (4) Disagree (5) Strongly disagree
12. Do you agree that healthcare organizations can run health services (including health care and drugs) for profit?
(1) Strongly agree (2) Agree (3) Undecided (4) Disagree (5) Strongly disagree
13. Do you agree that MFI should expand provision of healthcare (including health care and drugs)?
(1) Strongly agree (2) Agree (3) Undecided (4) Disagree (5) Strongly disagree
14. How likely are you to take a loan to run a pharmacy?
(1) Very likely (2) Somewhat likely (3) Undecided (4) Unlikely (5) Very unlikely
15. How likely are you to take a loan to run a clinic?
(1) Very likely (2) Somewhat likely (3) Undecided (4) Unlikely (5) Very unlikely

Health Expenditure

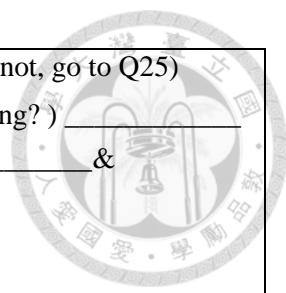
16. How much do you pay for this visit?

		Taka			
1	Consultation	<input type="checkbox"/> (1) <50 taka	<input type="checkbox"/> (2) 50-100 taka	<input type="checkbox"/> (3) 100-500 taka	<input type="checkbox"/> (4) >500 taka
2	Drugs	<input type="checkbox"/> (1) <50 taka	<input type="checkbox"/> (2) 50-100 taka	<input type="checkbox"/> (3) 100-500 taka	<input type="checkbox"/> (4) >500 taka
3	Test	<input type="checkbox"/> (1) <50 taka	<input type="checkbox"/> (2) 50-100 taka	<input type="checkbox"/> (3) 100-500 taka	<input type="checkbox"/> (4) >500 taka
4	Transport	<input type="checkbox"/> (1) <50 taka	<input type="checkbox"/> (2) 50-100 taka	<input type="checkbox"/> (3) 100-500 taka	<input type="checkbox"/> (4) >500 taka
5	Lodging	<input type="checkbox"/> (1) <50 taka	<input type="checkbox"/> (2) 50-100 taka	<input type="checkbox"/> (3) 100-500 taka	<input type="checkbox"/> (4) >500 taka
6	Others				
7	Others_____				

17. Overall, how do you think about the cost for this visit?
(1) cheap (2) reasonable (3) somewhat high (4) too high (5) Unreasonably high

Background

18. What is your age? _____ years
19. Where is your residence? _____ village/ town
20. What is your education level? (1) no education (2)primary incomplete (3) primary complete (4) secondary incomplete (5) secondary complete and above
21. What is your marital status? (1) unmarried (2) married (3) divorced (4) separated (5) widowed
22. How long do you live in this village/town? _____ years
23. How many people are there in your family? _____ people



24. If the respondent (or her family member) is a microcredit borrower, (if not, go to Q25)

24-1 since when are you or your family a microcredit borrower? (how long?) _____

24-2 do you take a health loan from the MFI? (1) Yes, how much _____ &
why _____ (2) No.

24-3 does your MFI provide health care? (1) Yes (2) No.

24-4 does your MFI refer you to any particular health provider? (1) Yes, indicate_-
_____. (2) No.

24-5 do you buy health insurance from your MFI? (1) Yes (go to Q24-6) (2) No.

24-6 if yes, how are you compensated for each outpatient care?

25. How much is your family income a month? (1) <4,500 taka (2) 4,500-8,000 taka
 (3) 8,000-15,000 taka (4) >15,000 taka.

26. What kind of work do you mainly do? Please specify _____

Thank you for your kind cooperation. Please leave your name and mobile phone number so that we could contact you in case our research team needs your further assistance.

Name of respondent _____

Mobile # of respondent _____