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# Community Based Health Insurance Schemes And Social Work Implications For Health Insurance Practices For The Poor

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**Abstract:** The unexpected and lump sum expenditures on health care are a cause of impoverishment and constant sense of insecurity to the poor. The Right to Health necessitates the availability of health care for all. The Community Based Health Insurance Schemes (CBHIs) are an innovative exercise towards participative contributory health insurance mechanisms designed to meet local needs. This paper explores the significance of CBHIs and understands the factors associated with the viability and sustainability of such organisations. The paper points out the role of social work interventions in the success of such micro health schemes to provide for the ultimate goal of health protection for all. The paper thus brings to the forefront the much needed collaboration between specialised interdisciplinary interventions in relevant aspects of policy implementation including the discipline of social work.

**Keyword:** Community Health Insurance, CBHIs, social work interventions.

## INTRODUCTION:

Lump sum medical expenditures which are incurred all of a sudden can be disastrous for a poor family. Many low and middle-income countries are still far from achieving universal health coverage. An estimated 1.3 billion people do not have access to effective and affordable health care, including drugs, surgeries and other medical facilities. As documented by the World Health Organisation, developing countries bear 93 per cent of the world's disease burden, yet merely account for 18 per cent of world income and 11 per cent of global health spending (WHO, 2004).

Health is also strongly related to economic growth as it decreases the loss in workdays. The health of the poor are even more affected by poverty as they work under hazardous conditions, live in poor unhygienic conditions and suffer from malnutrition (GTZ, 2007). The health sector in India is facing the double challenges of unpredictable diseases and the increasing life expectancy rates. Our health system does not have the ability to confront such spectrum of responsibilities. Hospitalisation cost has risen from less than Rs. 1,000 in 1986-87 to approximately Rs. 2,000 in 2004 at real prices. Similarly, per episode cost of treatment for an outpatient has increased in real terms from Rs. 33 in 1986-87 to Rs. 68 in 2004 (Selvaraj and Karan, 2009).

It is best when a government provides medical care through general taxation. This system is followed in the UK. In India too, this is the system followed but the percentage of spending is abysmally low (as percentage of GDP). Thus, the quality of health services provided is poor. In Europe, there is the social health insurance where the working population shares the disease burden of the entire population very similar to the CGHS (Central Government Health Scheme) and ESIS (Employees State Insurance Scheme) of India.

CGHS is a contributory health scheme that provides comprehensive medical care to the central government employees and their dependents. ESIS is an insurance system, which provides both cash and medical benefits to the poor factory workers and their dependents. Another 1.8 million people is covered by the private insurance sold through the semi-autonomous Government Insurance Company (GIC). Finally, the combined expenditures of the government, at the national, State and municipal levels, account for only one-fifths of all health care spending in India. Most government funds are used to provide services directly through public hospitals, clinics and programmes. A disproportionate amount of government spending is on curative services in urban centres.

However, the CGHS and the ESIS cater only to the members, not the entire population. Ninety percent of the population are not covered by insurance in India. In India, individuals and families on low incomes face significant barriers to accessing quality healthcare. Public health facilities suffer from poor management, low service quality, and weak finances. On the other hand, private health facilities are expensive, so that households typically have to borrow or sell assets to meet hospitalisation costs. At the same time, insurance companies have until recently shown little interest in offering health insurance products to poor groups. A search for alternative mechanisms for meeting the healthcare needs of the poor in India has given rise to a variety of new health insurance initiatives.

The Community based health insurance schemes are not of a recent origin. Many of them are over fifty years old. The main aim of these organisations is to improve the access to healthcare and treatment and reduce out-of-pocket expenditures of the communities who are socially,

economically and spatially disadvantaged. It improves the basic health parameters of the country through a democratic process. In fact, CBHIs cover less than 1% of the total population but speaking in terms of absolute numbers CBHIs cover more than 35 million people (Devadasan, 2006). In fact, welfare interventions can never follow the utility maximising theory of benefit for the maximum. It should definitely follow the theory of the rights based approaches that benefit for all, even if that may be one. The idea is to protect a person who needs medical expenditure by averaging out the risks among a greater number of people. Community based health insurance can also reduce inequities in health care access and treatment in the society.

**The need for insurance**

Against the general belief, it has been increasingly realised that the poor are able to save, in small periodic contributions, only if they are made to believe in it (Zeller & Sharma, 1998). Insurance separates time of payment from time of use of health services for each member, and thereby makes possible demand for such services by its members who would not have otherwise been able to afford the cost. Insurance is particularly beneficial to the poor who often bear high indirect costs of treatment due to their limited ability to mitigate risk because of imperfect labour and credit markets. In addition, community-based insurance is considered pro-poor as it strengthens the demand side and thereby helps the poor to articulate their own needs (Develtere and Fonteneau 2001). Neither the state nor the market is effective in providing health insurance to low-income people in rural and informal sector. The formal providers are often at informational disadvantage and face high transaction costs. On both these counts, health insurance schemes that are rooted in local organisations scores over alternate health insurance arrangements.

**Role of the state**

The lack of ability of the people to pay full insurance premium is considered the rational for providing external funding or subsidies on behalf of the state. Ahuja and Jutting (2003) hints at the various forms that subsidies can take without distorting incentives. Probably the best form of giving subsidy is in meeting start-up costs that are essentially of fixed-cost nature, and therefore, distort the incentives the least. By the same reasoning, subsidy can also be given for meeting certain recurring administrative expenses such as salaries of personnel, maintaining accounts, medical vehicle as well as equipment and so on. Furthermore, given the low capital base of the schemes, subsidy can also take the form of making funds available at low interest costs to cover the premium shortfall. The government can help to strengthen the support of health services. At institutional level, too government has a role in providing legal status to the scheme. Currently, most CBHI schemes have little or no legal standing, which tends to create some uncertainty in the minds of the public about the continuity of schemes. Providing legal status may inspire confidence among the local public, resulting in higher membership. Government can improve the risk management strategies of the poor through improved functioning of the labour, credit and product markets. Similarly, health security needs to be integrated with other government programs aimed at building income and health security for the poor.

**Role of NGOs**

The need for involving NGOs in health insurance schemes in India arises due to the following four factors. Firstly, In India, private expenditure accounts for roughly two-thirds of total health care spending. Almost all out- of -pocket spending was on curative rather than preventive care. Secondly, the quality of health care services available to the people in India is of poor standards. Services available through public health care facilities, which are supposed to be free but charged quite often. The private health care services available to the population are unaffordable. Thirdly, health insurance coverage in India is very limited particularly among those who work outside the formal sector. Most of the insurance schemes are in the form of social security. This allocative inefficiency is unlikely to be corrected (Dhingra, 2001).

**Socio-economic impacts of social protection of health**

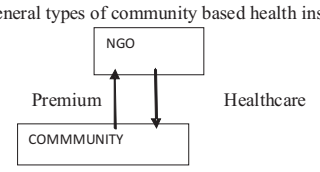
Health and social security are human rights. They are prerequisites to the elimination of poverty and morbidity of a country. Social protection of health moves beyond just protecting the poor against impoverishment by addressing the questions of social exclusion, unequal gender relations and low levels of awareness. Better health improves productivity. Most so, it can reduce the waste in household expenses on sudden spending towards useful expenditure thereby increasing consumption. It contributes to social cohesion and peace.

**Community based health insurance (CBHI)**

Community based health insurance is a recent innovation that has taken roots in Africa and is now being introduced into Asia. CBHI uses the strategy of health insurance wherein people pay a small contribution at the beginning itself. These contributions are pooled to provide benefits (medical costs) for those who need it. The addition in CBHI is that the community usually initiates and manages it. This difference is very important, as it implies that the CBHI is developed to meet local needs. The main strengths of a CBHI are that it is owned by the community and so there is a strong will to make it succeed. The design suits the local needs and requirements. Finally, the scheme is usually co-managed by the people, so the administrative overheads are low.

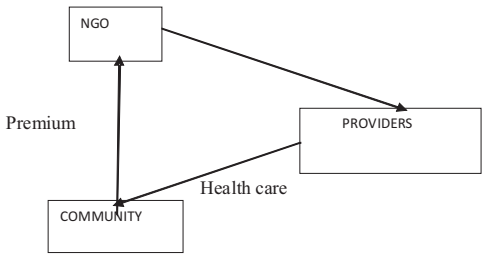
The general types of community based health insurance models can be as follows:

1)



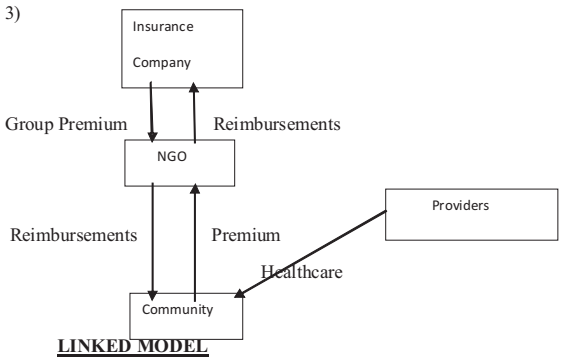

**PROVIDER MODEL**

2)




**INSURER MODEL**

3)




**LINKED MODEL**

**Evaluation of CBHIs in India**

The CBHIs in India follow the provider, insurer or the linked model. In the provider model the insurer and the healthcare provider is the same organisation. The community pays the premium to the organisation and in return gets the healthcare from them. The insurer model has a separate provider of healthcare with the NGO acting as the insurer. The linked model has separate insurers and providers.

Among the provider-based models, there is the ACCORD-AMS-ASHWINI health insurance in Gujarat, the Jawa Health Insurance scheme in Maharashtra, the Medical Aid Plan of Voluntary Health Services in Chennai and the Students' Health Home in Kolkata. The insurer model included schemes like MIS-RAHA in Chattisgarh, the KKVS-Dhan Foundation in Tamil Nadu and the Yeshavini Health Insurance programme in Karnataka. The Linked models that are in India include the SHADE in Kerala and the VIMO-Sewa in Gujarat. Irrespective of the design, all the schemes have scored well in improving access and protection of the community members against health scares in terms of enrolment, treatment and adjusting claims. However, in terms of the other two goals of such community based efforts like increasing the community solidarity and community participation, all the schemes have yet to impress the scholarship Devadasan, 2006). This requires attention as these schemes do have the maximum scope of having community-based interventions.

Critical CBHI design features that affect enrolment include the co-payment (that is the part of the payment that has to be paid by the member) and waiting period (that is the time within which the claims are adjusted) for insured patients, the insurance benefit package, CBHI management and the provider payment. Many CBHI have a 6-month waiting-time for new members before they may benefit from insurance coverage (Bennett et al. 1998). This feature may create mistrust about the financial management of CBHI and negatively affect the expected pay-off of CBHI, as well as enrolment. Whether the size and composition of the CBHI benefit package corresponds to poor people's needs also affect their enrolment decision (Schneider, 2004).

**Access to healthcare and CBHIs:**

There is evidence that community based health insurance schemes have the possibility of increasing the access of the community to primary and secondary healthcare particularly of the elderly and pregnant women (Schneider and Diop, 2004; Ju¨tting 2003; Ranson, 2003; Dror 2005).

In one such study on ACCORD-AMS-ASHWINI (AAA) Community based health insurance scheme, Devadasan et al (2010) showed that access to hospital care was better among the insured than the uninsured from a cohort study with similar economic, social and demographic parameters. The encouraging fact was that the vulnerable sections of the population namely, the aged, the children, the women and the poorest were the most benefitted. Since this organisation followed the provider-model, most of the ailments were treated in the ASHWINI hospital. The main reasons for this increased access were analysed to be credible and trustworthy organisers and providers; simple procedures for hospital access for the beneficiaries; low transport costs and low co-payments and exclusions. This higher access was also seen in patients with pre-existing illnesses. For community based schemes to succeed there should be transparency in its operation. It should be non-discriminatory among the social partners in product as well as in process. Corruption, which can very easily permeate in these small groups, can be fought significantly through peer influence and community involvement.

**Importance of field data, documentation and research**

There is absence of adequate data on Community based health insurance schemes. Very recently, schemes in Africa, Latin America and Asia have received the attention of worldwide donors and documentation has started on various aspects of the CBHIs. However, instead of plain and descriptive case studies there is a need for methodologically sound research studies that looks into specific dimensions of healthcare delivery and management of such schemes. Baeza (2002), in a study on 258 schemes found only one study, which he found to be methodologically sound. He stressed on community-based research. This will facilitate field interventions for replication and adaptation. Most of the studies focussed on the coverage aspects of schemes while very few analysed deeply other variables like utilisation, finances and other structural comparisons between different

models. There is a need to focus on the issues of community solidarity as encouraged by the community based models or the scope of such interventions therein. Participatory involvement in the welfare systems is another aspect that these models have encouraged.

**The supply side dynamics**

The considerable pressure on the existing health delivery system of the government makes it an easy observation that many intending beneficiaries try the private health care providers. While most of them fail to utilise the said facilities due to the enhanced costs as compared to the state systems, some do actually prefer to utilise the private hospitals and nursing homes, as the quality of treatment is more satisfactory. The private sector accounts for nearly 82% of total outpatient visits, 52% of all hospitalisations and nearly 100% of all out-of-pocket expenditures (GTZ, 2007). However, the escalated costs that the community has to bear make room for community based people-centred schemes.

**Field based interventions**

Any community level intervention has the tremendous possibility of facilitating solidarity among the community members as well as in enhancing the level of participation of the community in the protection of their welfare delivery. The CBHIs hold a lot of promise in that respect, particularly as the time has come to focus not only on the products of welfare delivery but also on the process of the same. Devadasan (2006) had compiled ten case studies of CBHIs in India that brings out the fact that although the schemes have been successful in increasing the access to health care and protection of the communities against the vulnerability of treatment of sudden sicknesses in various degrees. Very few of the schemes, irrespective of the models, location, size and technical specifications, have been effective enough to increase solidarity in the target community and even fewer of them have they been successful in increasing the participation of the community in the working of the schemes.

A better inclusion of the poor is perhaps possible with a wider network that is with a more heterogeneous population. This has to be carefully balanced to suit the convenience of administration of a larger group by the members. Inclusion of the poorest of the poor is another challenge that these organisations have to improve upon. The family was mostly seen as the unit of enrolment to lower adverse selection. Most of the CBHIs have been successful when they have connected with some of the existing organisations like self-help groups, trade unions, cooperatives, NGOs and of course hospitals. Depending on such existing resources, the design of the model is worked out. The community is the best advisor in terms of suitability of the premiums, their collection and evasion of moral hazard. Whereas the linked model turns out to be rigid, it has the least exclusions. Linkage with a hospital is vital and for this, many NGOs become providers of medical care themselves or link up with a private or non-profit organisation. In terms of collection, administration and verification, community control of fraud is very effective. Regular feedbacks from the community increase the acceptability of the scheme. The efficiency of a scheme is enhanced with a better negotiation skill of the members of the community with the providers. An effective management information system that is suitable for the communities is necessary to keep a personal account of the transactions so that the negotiations with the providers can be done judiciously.

**Importance of networking and advocacy**

The concept CBHIs is still in the necessity of national dialogue to widen its coverage. There is also the need for developing appropriate methodologies in health financing, collection of revenues, risk pooling and purchasing of services, designing benefit packages and engage in fund management activities. Continuing dialogue with the national and international development thinkers can encourage flow of information about the different approaches followed in different countries and devise an effective methodology. A strong networking with the academic and government institutions can produce relevant evidence on feasibility, costs and benefits of social protection systems.

**Monitoring and evaluation**

Any group activity that involves a revolving fund needs constant monitoring and evaluation. The same is the case with Community based health insurance systems. Whereas monitoring can be an initiative specific to a country, evaluation can have broad international parameters. Benchmarks for specific targets like reduction in out-of-pocket expenditures and increase in healthcare expenditures can be specified to make the processes uniform.

**Development of capacities and skills**

A CBHI is a result of s continuous dialogue and development of knowledge. Sharing of experiences followed by adapting of the strong points of some of the success stories can be very easily done with the help of a trained team of dedicated workers. This requires skill development of people from the community who show the potential to lead. At another level, the analysis of socio-economic consequences and examination of linkages has to emanate from the resources within the community to make them successful and sustainable.

**Importance of trained facilitators**

The nightmare of a failed cooperative movement still haunts us. A community based health insurance scheme is built much across the same ideology. It is an organised endeavour to involve specific communities to participate in the keeping of their own good health. It is a simple core ideology that the poor must be protected, particularly those who are unable to withstand the sudden onus of lump sum payments for medical expenditure. Resource personnel who are trained in field practices and welfare ideologies are significant in promoting and protecting the safe working of such community organisations. The trained social workers appropriately fit in such positions. The community based health insurance organisations provide a fertile ground for the exercise of an interdisciplinary endeavour of social

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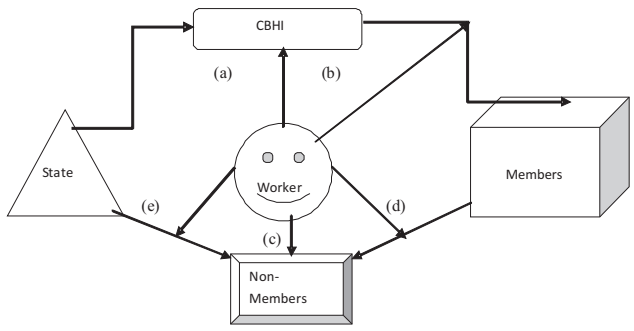
planning, social leadership, social mobilisation of capital, medicine, management and of course social work.




Concentrating on social worker as a significant facilitator it can be easily understood from the diagram above, that s/he has the potential to hold a central role in all linkages (and perhaps many more) emanating from the community based health insurance organisation. Most importantly, the worker can serve as an important link with the community to communicate effectively as regards the requirements, problems and suggestions from the community to the CBHI both directly (a) and indirectly (b). They can contribute to the planning, designing, deciding parameters and documenting for the CBHI directly. They can also support the functioning of the health insurance schemes in collecting the premiums, doing a need-based analysis of the exact requirements of the community, preventing adverse selection and moral hazards.

The more the members the better will be the capital base. Thus, the worker can with his casework, group work and community organisation skills increase the array of members. This they can do directly (c) or indirectly through the existing members (d). The state as a stakeholder can do its bit by legalising the CBHIs, which will automatically bring in a sense of security in the minds of the members. The worker can actively advocate for such a necessary step as well as for providing incentives to the non members as well as the members to collectively make the scheme a success by joining in it and remaining as active members in it. Community health insurance schemes can be initiated by linking up with existing NGOs, cooperatives, hospitals, self-help groups etc. It may also be judiciously tied up with government schemes like the Rashtriya Swasthya Bima Yojana (RSBY) as a first step towards universalisation of health care.

Thus, it is yet another domain of interdisciplinary action, which remains to be explored and conquered.

## CONCLUSION

It has been increasingly felt among the scholarship that social work has now started to contribute towards development as against the stamped image of a remedial and/or an activist discipline (Midgley, 2009). This is welcome as the profession has a dying existence in developing countries including India in the absence of an integrated system of functioning under one umbrella organisation. This is paradoxical too, as the scope for the profession is on a tremendous rise and spread with the wave of globalisation.

The paper was an attempt to locate social workers in social welfare schemes as a professional and not as graduates or post-graduates who have got the job alongwith co-workers who are from any other discipline. The social worker should be able to practice his learning in the field to mobilise and organise the community to join the social health insurance systems.

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