I J Pre Clin Dent Res 2014;1(3):56-61
July-September
All rights reserved

International Journal of Preventive &
Clinical Dental Research

Community Based Health Insurance- A Testimony for Uplifting the Health of the Poor

Abstract

Financing is the most critical of all determinants of a health system. The nature of financing defines the structure, the behaviour of different stakeholders and quality of outcomes. Under a system dominated by out-of-pocket expenditures, the poor, who have the greater probability of falling ill due to poor nutrition, unhealthy living conditions, etc. pay disproportionately more on health than the rich and access to health care is dependent on ability to pay. Assessing how pro-poor a system of financing is again depends on how the different types of financing interact with each other. In that case, the poor who have no immediate access to insurance or private hospitals may stand to lose with poor quality public care. Because, if funding is low and the quality of care falls below expectation, is inaccessible, entails informal payments, etc. then the benefit of free care at the public facility gets neutralized with the second option of paying out-of-pocket to a relatively hassle- free private provider available close by, making the system of financing inequitable as well as inefficient. The article argues for strengthening public investment and expenditure in the health sector and suggests possible options like community health insurance. It also calls for a reform of the existing healthcare system by restructuring it to create a universal access mechanism as Community health insurance is an important intermediate step in the evolution of an equitable health financing mechanism.

Key Words

Out of pocket, finance; community based health insurance

Dr Shwetha HL[1], Dr Mayur Nath T Reddy[2], Dr DP Narayan[3], Dr K Vijetha[4], Dr Priya Sridhar[5], Dr Gaurav Patel[6]

[1]Senior Lecturer, Department of Public Health Dentistry, Vydehi Institute of Dental Sciences & Research Centre, Bangalore, Karnataka, India
[2]Associate Professor, Department of Public Health Dentistry, Vydehi Institute of Dental Sciences & Research Centre, Bangalore, Karnataka, India
[3]Principal, Professor & Head, Department of Public Health Dentistry, Vydehi Institute of Dental Sciences & Research Centre, Bangalore, Karnataka, India
[4]Post Graduate Student, Department of Public Health Dentistry, Vydehi Institute of Dental Sciences & Research Centre, Bangalore, Karnataka, India
[5]Intern, Vydehi Institute of Dental Sciences & Research Centre, Bangalore, Karnataka, India
[6]Senior Lecturer, Department of Oral & Maxillofacial Surgery, Vydehi Institute of Dental Sciences & Research Centre, Bangalore, Karnataka India

INTRODUCTION

In financing of health services a country may, in principle, choose between public financing through general taxation or private financing through health insurance.[1] Public financing is justified where equity concern overrides efficiency objective. Where the opposite is true, reliance is often placed on the private insurance market.[2] Equity considerations in private insurance market can generate inefficiency and market failure as it involves tradeoff between desired distribution and the distorted incentives that accompany such redistribution. Therefore, where equity is the prime consideration it can best be achieved under public financing. In practice no health financing system is either purely public or private.[3] Countries where private health insurance dominates, some public financing can still be observed. Similarly, some private insurance can be seen even in a public funded health system.[4] All insurance systems, public or private, must strike a balance between economic efficiency and equity.

DEARTH OF RESOURCES

For the low-income people, insurance was never considered to be an option in the past. They were assumed to be too poor to save and pay premium.[5] Hence, the government assumed the responsibility of meeting health care needs of the poor. Shrinking budgetary support to the public health services, inefficiency in provision and unacceptably low quality of these services is reflective of this.[6] First, it is being increasingly realized that even low-

income people can make small periodic contributions, which can add up to a significant amount, thereby taking some financial burden off from the already strained state revenues.[7] Second, the insured individuals would have an option of going to either public or private service provider, which in turn would generate competition among providers for better services.[8] Finally, health insurance can be used to promote certain desirable behavior.

CROSS-SUBSIDIZED POLICIES - A UNIFORM SOCIAL OBLIGATION

In the past, public insurer cross-subsidized the policies meant for the disadvantage sections of the society.[9] Now, for cross-subsidy to work properly, a uniform social obligation needs to be imposed on all insurance companies and not only on public insurers. Such an obligation would then come from the regulator and not from the government.[10,11] The regulator, for example, could mandate all insurance companies to offer "basic" benefit package covering maternal, preventive, catastrophic and chronic care at standard prices to the poor, especially in rural areas with some subsidy from the government.[12] In this case, the regulator may limit exclusions, mandate guaranteed renewal, and make accreditation of service provider public. Here too NGOs can play a crucial role as an intermediary between the private insurers and the community.[13] Whether having a cross-subsidy obligation uniformly on all insurance companies is the best (most efficient) way of reaching the poor is an open question. Generally, subsidy that comes from general revenue of government is the most progressive.[14]

ACCOUNTABILITY OF HEALTH INSURANCE

Once the entry barriers are removed, additional regulations need to be put in place for the smooth functioning of health insurance business.[15] Even though, insurance regulations meant to ensure fairness, efficiency, and financial accountability in health insurance are similar to those applicable to general insurance business, health insurance business always involves additional regulations. These relate to meeting social objectives of access, adequate benefits, and consumer responsiveness. Typically insurers tend to develop a number of underwriting and pricing practices to avoid accepting high risk people.[16] This kind of market segmentation is economically efficient but may be considered socially unacceptable. Often regulators ensure that equal access is available to the payers of health care, that companies cannot exclude high-risk individuals or costly preexisting conditions.[17] Moreover, health insurance contracts are typically more complex than other insurance contracts. Regulators need to ensure that consumers understand the provisions of the contracts and that contract are written in a manner understood by the buyers. Developments on the health insurance front will not leave the poor unaffected. Even though private for-profit insurance companies are not expected to voluntarily provide health insurance cover to the poor, the poor may still be affected on account of the influence that development of health insurance will have on the supply of such services.[18] Furthermore, the poor may also directly benefit if insurance regulations are specifically designed to achieve redistribution and equity objectives. At the minimum the government must ensure that i) the liberalization of insurance market provides value for money for the direct beneficiaries; ii) the poor are not adversely affected by the liberalization. However, the government can definitely aim higher by ensuring that the poor too benefit from the developments in health insurance.

COMMUNITY BASED HEALTH INSURANCE FOR THE POOR

The poor might benefit from the expansion of private providers if the supply of health care expands due to increase in affordability resulting from health insurance.[19] However, if prices grow faster than delivery capacity, cost escalation may even expand the existing gap between the poor and the required access to health care. All this is unpredictable, since it depends on the supply response of health care and the model of health insurance implemented in the country.[20] Regarding the latter, it is clear that an indemnity/fee-for-service system will unavoidably result in a severe cost escalation whereas a managed care which coordinates financing and delivery of healthcare would probably be capable of maintaining costs under control. Managed care by containing of unnecessary treatment helps in containment of costs and thereby makes health insurance more affordable to larger number of people; provides incentives for improving healthcare delivery; promotes preventive care such as medical check-ups, immunization and so on. Since fee-for-service approach to payment of health providers tends to escalate costs the government should encourage managed care models. The pro-poor recommendations made in the

World Bank organized national seminar on the topic are: i) reduce the public subsidy to the wealthy by charging full cost recovery to the insured who use private insurance; ii) define minimum package of services cover that include preventive, maternity, and catastrophic cases; iii) encourage informal community financing schemes, for example, managed care schemes through NGOs with less regulation and lower capital deposit requirements.

Health insurance scheme for the poor should take care of not just the inpatient or hospital care, as designed in the proposed scheme, but also of the outpatient care. It is often suggested that insurance be provided only for inpatient care and that outpatient care be left outside the ambit of insurance. The reasons given are: that people can, by and large, afford out-patient care because it is relatively inexpensive; it is the inpatient care that pushes them into poverty trap; that administratively it is difficulty to include out- patient care; and, that out-patient care would lead to cost escalation. Ideally, both in- patient care and outpatient care be covered, and the decision of whether or not a patient needs hospitalization be professionally made and should not be a function of whether or not the patient has health insurance cover. For this reason the UNDP sponsored experiments on community based health insurance, launched recently, have addressed the issue of outpatient care as well. Community character of CBHI schemes is used to tackle the problem of outpatient care as well.[21] However, with the launch of universal health insurance scheme, it is not clear how this would affect the prospects of an NGO negotiating a health insurance package for and on behalf of a target community with the public insurance companies.

In India, there appears to be three basic designs, depending on who is the insurer. In Type I (or HMO design), the hospital plays the dual role of providing health care and running the insurance programme. In Type II (or Insurer design), the voluntary organisation is the insurer, while purchasing care from independent providers. And finally in Type III (or Intermediate design), the voluntary organisation plays the role of an agent, purchasing care from providers and insurance from insurance companies.

A comprehensive benefit package is necessary to convince the community of the benefits of health insurance.[22] Most of the CHIs documented, especially the Type I schemes have provided a comprehensive package and this is one of the main reasons why people have enrolled in their schemes. Unfortunately, most of the Type III schemes have been forced to introduce exclusions by the insurance companies. While most insurance companies introduce exclusions, based on economic reasons, one has to look at health insurance within a public health context.[23] Diseases like TB, HIV and mental illnesses have significant public health importance and should be covered. Similarly it is ironic that while the country has invested tremendously in safe deliveries, most health insurance products do not cover it.[24] And finally as India enters an epidemiological transition and will have to encounter chronic diseases like diabetes and hypertension, it becomes imperative that these diseases are included in the benefit package.

INSURANCE SECTOR REFORMS

Where an NGO itself provides insurance to the target community, insurance sector reforms do not directly affect formation of such schemes, though appropriate regulatory changes designed to encourage such grouping may positively affect their formation.[25] The scope for introducing such changes is greater now than prior to liberalisation. Where insurance reforms do affect is in non-community based scheme (where the government directs public insurance companies to offer a product to the poor with or without some subsidy from the government) as well as in NGO mediated CBHI scheme (where an NGO ties-up with the formal insurance provider in ensuring certain benefit package to the targeted poor). Both these types of schemes were more likely when insurance was a public monopoly.[26] Now with the introduction of competition, for-profit companies will voluntarily serve only those segments and introduce those products that are profitable in descending order of magnitude to the company. Typically, providing insurance to the poor is not profitable and insurance companies are unlikely to take up this moral obligation on their own volition. Furthermore, even public insurers that have mostly entered into such commitments may no longer be willing to do so as competition in the market intensifies. The regulator imposed uniform obligation across all formal insurers can then improve the prospects of NGO-mediated CBHI or non-community based scheme for the low-income people. The current social and rural sector obligation imposed by the Insurance Regulatory and Development Authority (IRDA) is on the insurance business in general and does not specifically apply to health insurance. Furthermore, this obligation

does not require insurance companies to subsidise premium. This obligation is just to ensure that some amount of insurance activity also moves to rural areas and doesn't remain confined to big cities and towns. A credible insurer is imperative for people to have faith in the product. This is where the NGOs and the CBOs score as they have a relationship with the community and so the people are willing to trust them with their money.[27] Insurance companies need to learn from this important lesson and would need to approach the rural sector keeping this in mind. The administration load of the scheme and unnecessary documentation on the community should be minimal. This is where the Type I and Type II schemes score over the others.

TRANSACTION COST TO BE LOW

The real benefit of CBHI lies in keeping the transaction costs low, in the design of scheme suited to the community needs, in influencing health behaviour through health education, and in influencing the supply of health care.[28] Popularising insurance among low-income people requires conveying the idea, canvassing for it, collecting premium, and verifying claims and then reimbursing these claims. In case of formal providers, all these functions typically take up significant part (at least 20 per cent) of the premium amount. In CBHI schemes such costs can be kept low, say to 5-6 per cent. This is because many of these tasks can be performed by the community members themselves.[29,30] Besides, in poor communities financial barrier is only one of the barriers to accessing health care. Often, there are many non-financial barriers that must also be overcome through the design of schemes which ought to take into account characteristics of the community.[31] All these aspects can best be handled if the scheme is community based. Additionally, the problems of adverse selection and moral hazard that arise due to informational asymmetries too can be reduced by making use of local knowledge that is readily available among people living in close communities. Community Based Health Insurance scheme is more appropriate in reducing informational asymmetries. Community Based Health Insurance schemes also help in influencing provision of health services. By its very nature, CBHI scheme can be designed to meet health care needs that are specific to a community. Generally, Community Based Health Insurance scheme is organized through a Non-Governmental Organizations that is conversant with the target community. A CBHI scheme where an NGO mediates between community members and the formal insurance provider seems to combine the participatory feature with the efficiency aspect characteristic of the formal insurance provider.[32] However, some forms of CBHI also have important limitations. For example, where an NGO itself provides insurance (acts like an insurer) the ability of the NGO to have a pool of well diversify risk is limited. This in turn restricts the ability of NGO to cover or insure variety of risks facing the target population. Moreover, where CBHI schemes are critically dependent on external funding, extending the reach of these schemes then depends on the amount of such funding available.[33-35] Furthermore, the insurance schemes launched either by national or state-level governments when elections are in sight tend to be populist or vote-catching ploy. Since such schemes have to be renewed every year, these tend to be dropped once the elections are over. It is to be seen if universal health insurance scheme belongs to this category.

CONCLUSION

CBHI, which is more appropriate insurance arrangement for the poor, could take different forms and each of this form may be suitable depending on the characteristics of the target population, their health profile, and health risks to which the community is exposed. But increased public health spending and reforming of public health facilities is a must for the success of these community based health initiatives. In a country with one of the highest out of pocket health care expenditure in the world, it is imperative that some measures be instituted to protect the poor. We suggest that community health insurance could be an interim strategy to finance the health care of the people; till a more formal social health insurance is in place. We also suggest that this is a feasible alternative given that community based organizations and movements exist in India. What is required is to regulate the providers and to legislate so that the community health insurance programmes find a space within the Indian insurance context. Formal insurance providers can also be reined to serve low-income population. At the same time, developments in formal health insurance market need to be guided so as to minimize cost escalation of health care provision.

REFERENCES

1. Bhat R, EB Reuben. Management of Claims and Reimbursements: The Case of Mediclaim

Insurance Policy. Vikalpa 2002;27(4).

2. Chollet, D, Lewis M. Private Insurance: Principles and Practice, in George J. Schieber edited “Innovations in Health Care Financing: Proceedings of a World Bank Conference”, World Bank Discussion. The World Bank, Washington DC 1997;365:10-11.
3. Ferreiro A. Private Health Insurance in India: Would its Implementation Affect the Poor? Private Health Insurance and Public Health Goals in India. Report on a National Seminar, the World Bank, May 2000.
4. Garg C. Implications of Current Experiences of Health Insurance in India, Private Health Insurance and Public Health Goals in India, Report on a National Seminar, the World Bank, May 2000.
5. Government of India. Health Insurance-Issues and Challenges, Report of the Sub-Group, Ministry of Finance. Delhi, 2002.
6. Gumber A. Burden of Disease and Cost of Ill Health in India: Setting Priorities for Health Interventions During Ninth Plan. Margin 1997;29(2):133-72.
7. Gumber A, Kulkarni V. Paper presented in the National Consultation on Health Security in India Organised by Institute for Human Development and UNDP with support from Ministry of Health and Family Welfare, Government of India, July 26-27, 2001.
8. Mahal A. Private Entry into Health Insurance in India: An Assessment, Private Health Insurance and Public Health Goals in India, Report on a National Seminar, the World Bank, May 2000.
9. Misra R. Changing the Indian Health System: Current Issues, Future Directions, Oxford University Press, New Delhi, forthcoming 2003.
10. Rangachary N. The Concept of Health Insurance, Health and Population-Perspectives and Issues 2001;24(2):73-9.
11. Ranson K, Jowett M. Developing Health Insurance in India: Background Paper to the Government of India Workshop on Health Insurance, January 3- 4, 2003, Delhi.
12. Ramesh B, Dileep M. Health Insurance in India: Opportunities, Challenges and Concerns, Indian Institute of Management, Ahmedabad 2000.
13. Government of India. ‘Annual Report, 1993-94’, Ministry of Health & Family Welfare 1994.
14. Kent R, Akash A. ‘Community based health insurance: The Answer to India’s Risk Sharing Problems?’ Health Action 2003 March.
15. Kent R, Matthew J. ‘Developing Health Insurance in India: Background Paper’, Prepared for Govt. of India Workshop on Health Insurance, 3- 4th January, New Delhi 2003.
16. Mahal A, Singh J, Afridi F, Lamba V, Gumber A. Who benefits from public health spending in India. New Delhi: National Council of Applied Economic Research; 2001.
17. National Sample Survey Organisation (NSSO). Morbidity and treatment of ailments. Report No. 441. New Delhi: Department of Statistics, Central Statistics Organisation, Government of India; 1998:A-170.
18. National Sample Survey Organisation (NSSO). Morbidity and utilization of medical services. Report No. 364. New Delhi: Department of Statistics, Central Statistics Organization, Government of India; 1989:A-13.
19. Prabhu KS. Social sector expenditures and human development: A study of Indian states. Bombay: Development Research Group, Reserve Bank of India; 1993.
20. Selvaraju V. Health care expenditure in rural India. Working Paper No. 93. New Delhi: National Council of Applied Economic Research; 2003.
21. Tanzi V, Schuknecht L. Public spending in the 20th century: Global perspective. Cambridge: Cambridge University Press; 2000.
22. World Bank. World Development Report 2004: Making services work for poor people. World Bank; 2003:256-7.
23. Atim C. ‘Contribution of Mutual Health Organisations to Financing, Delivery, and Access to Health care: Synthesis of Research in Nine West and Central African Countries’, Bethesda, Maryland, Abt Associates Inc 1998:82.
24. Barnighausen T, R Sauerborn. ‘One Hundred and Eighteen Years of the German Health Insurance System: Are There Any Lessons for Middle- and Low-Income Countries?’ Soc Sci Med 2002;54:1559-87.

25. Ramesh B. 'Characterisitics of Private Medical Practice in India: A Provider Perspective'. Health Policy and Planning 1999;14(1):26-37.
26. Dror D, Jacquier C. 'Micro-Insurance: Extending Health Insurance to the Excluded'. International Social Security Review 1999;52(1):71.
27. Mahal A, Singh J. Who Benefits from Public Health Spending in India? The World Bank, New Delhi, 2000.
28. Naylor CD, Jha P. A Fine Balance: Some Options for Private and Public Health Care in Urban India, The World Bank (Human Development Network), Washington, DC, 1999.
29. Peters D, Yazbeck A. 'Raising the Sights: Better Health Systems for India's Poor', The World Bank (Health, Nutrition, Population Sector Unit) 2001:173.
30. Peters DH, Yazbeck AS. Better Health Systems for India's Poor: Findings, Analysis, and Options, The World Bank, Washington DC, 2002.
31. Preker A, Carrin G. A Synthesis Report on the Role of Communities in Resource Mobilisation and Risk Sharing, Geneva, WG3, CMH, World Health Organisation 2001:41.
32. Ranson MK. 'Community-Based Health Insurance Schemes in India: A Review'. National Medical Journal of India 2003;16(2):79-89.
33. Ranson MK, John KR. 'Quality of Hysterectomy Care in Rural Gujarat: The Role of Community-Based Health Insurance'. Health Policy and Planning 2001;16(4):395-403.
34. World Health Organisation. The World Health Report 2000: Health Systems: Improving Performance, WHO, Geneva, 2000.
35. Yip W, Berman P. 'Targeted Health Insurance in a Low Income Country and Its Impact on Access and Equity in Access: Egypt's School Health Insurance'. Health Economics 2001;10:207-20.