Risk-sharing in rural health care

The author describes a health insurance scheme covering a group of villages in India, whereby people contribute according to their ability to pay and services are provided according to need.

Kasturba Hospital in Sevagram, India, has helped to initiate an outreach health programme for nearby villages. A health insurance scheme has evolved to a point where the community contributes financially and participates in decision-making and the supervision of village health workers.

Some of the problems encountered have been reported previously in *World Health Forum* (1, 2).

Health insurance contributions

Most contributions towards health insurance are made as sorghum, which provides the basis for a fund used to support an outreach health programme and other development activities. Contributors are entitled to free primary care and subsidized referral care.

The purpose of establishing a village fund was not to raise financial support for the outreach programme but to generate demand for service of high quality. Since the existence of health care does not necessarily mean that it is accessible to the poorest people, health insurance contributions were determined according to ability to pay. The villagers were already accustomed to making voluntary contributions on this basis for religious functions, sports events, and so on. The health contribution from members of the lowest income group, the landless labourers was 8 payali (about 10 kg) of sorghum per family per year. The landowners contributed 5 payali per hectare. The village health workers collected the sorghum at a given time and place each year. Anyone failing to make a contribution on the specified day was not allowed to benefit from the health insurance scheme during the following year.

The village fund covers drug costs, the travelling expenses of the mobile health team, and the remuneration of the village health worker.

Strategy

Only villages where at least 75% of the poor community agreed to enrol in the health insurance scheme were adopted by the hospital. In villages where membership dropped below 75% the scheme was

---

Dr Jajoo is Associate Professor of Medicine, Mahatma Gandhi Institute of Medical Sciences, Sevagram 442 102, Wardha, India.
withdrawn. If this happened the situation was discussed with the people and corrective action was taken. Enrolment tended to decline where political polarization occurred and the scheme became identified with a particular faction. Where a conscious effort was made by the hospital to avoid identification with party politics, withdrawal of the scheme due to lack of support usually had the effect of motivating the community to reorganize, and in most cases reinstatement followed.

Ways of providing efficient community vaccination and maternal care were worked out. Annual pulse-strategy immunization (3) needed only four village visits a year and achieved 95% adequate results, while maternal surveillance required three village visits a year in order to detect mothers at risk. The hospital is the base from which outreach visits to villages are made. A team comprising an auxiliary nurse-midwife and a social worker looks after 20 villages on a regular basis.

People’s attitudes to the scheme varied according to the distance of the hospital from their homes and its accessibility by road. Distances of up to five kilometres presented no problems, but remote villages could only be adopted if regular transport services were available.

**Benefits**

The hospital offers insured persons free inpatient treatment for unexpected illness and a 75% subsidy for care during normal pregnancy or in cases where treatment has been planned, as with cataract and hernia operations. The free inpatient service assures accessibility of hospital treatment for the poor. The hospital receives 75% of its money from government and the rest as charges and donations; the outreach services are totally supported by village funds. Non-members can use the facilities at full cost. The mobile health team, comprising auxiliary nurse-midwife, social worker and village health worker, provides maternal and child health services in the localities where people live.

The village health workers provide symptomatic drug treatment, exercise a preventive and promotive role with the help of visiting health team members, refer patients to hospital, and act as a link between the hospital and the community for other village development activities.

The auxiliary nurse-midwife and social workers organize peripheral visits for the purpose of vaccination and provide maternal and child health care. They also follow up all inpatient cases and endeavour to ensure compliance. The doctor in charge acts as a supervisor, treats patients in hospital, gives illustrated talks on health education, coordinates village meetings on health matters, and trains village health workers.

**Decision-making**

Village meetings are held annually before the sorghum contributions are received. They are organized by the doctor in charge and attended by auxiliary nurse-midwives, social workers and village health workers,
the objective being to examine the performance of the health delivery system and to decide on disciplinary action in respect of any irregularities for which villagers have been responsible. The village meetings serve as a vehicle for communication between the health team and the people, and give the villagers an opportunity to exercise control over the village health workers.

**Achievements**

More than 75% of the villages in the area have enrolled in the scheme over the last ten years. Poor people have joined more readily than the better-off members of village communities. Films are no longer used in health education, meetings and discussion groups having proved more effective as means of communication.

As a rule the people of the insured villages had no inhibitions about being hospitalized, a good indication of the accessibility and quality of the care provided.

No vaccine-preventable illness (measles, poliomyelitis, diphtheria, whooping cough, tetanus) was reported in children or mothers after mass immunization was instituted, no maternal deaths have occurred during the past ten years, and perinatal mortality has fallen steeply.

The yearly village meetings have helped to build public awareness of health issues and to heighten the sense of responsibility among both villagers and care providers.

The village health teams are now regarded as guides and counsellors on a wide range of health-related matters, among them drinking-water supplies, irrigation and programmes for income generation.

**Scope for improvement**

Although hospital services have been made accessible, preventable deaths during delivery and in the immediate postpartum period still occur, mostly because of poor communications and transport in emergency situations.

Deaths linked to malnutrition in children aged under five years continue to occur. Mothers in the poorest socioeconomic group are not receiving adequate nutrition. Prolonged hospitalization of severely malnourished babies causes mothers to lose their wages. Many people still believe that this illness is caused by evil spirits. There is a tendency for baby girls to be particularly subject to neglect where poverty prevails.

Despite the health education drive, a demand persists for tonics and injections. If the public service does not respond, the villagers go to private practitioners.

Community participation in health development continues to be minimal. This seems to be because health is a matter of low priority for most people; needs are often of brief duration and are felt by individuals, not by the community as a whole, at any given time.

Sound primary health care cannot come from above. Communities should own and run their health services. Given the
prevailing modes of production, structure of society and distribution of political power, this may seem an unrealistic aspiration. The small-scale scheme described here is not an oasis in which the right to health care can be exercised from below. Within the existing social limitations, however, it offers a replicable model.

A financing system that works well

The system of obtaining funds from community members according to their ability to pay has yielded the following benefits:

- increased accessibility of basic health services;
- increased concern for health in the community;
- services acceptable to and responding to the priorities of the community;
- a perception by people that they have a right to demand health care of high quality;
- risk-sharing;
- stimulation of self-confidence, organizational ability, and development activities.

It is necessary to regulate the private health sector, including professionals, the drug industry, and investors.

The application of the principle of contribution according to ability to pay in conjunction with the provision of services according to need led to an equitable system free of adverse selection. The desirability and affordability of the scheme helped to bring about revenue stability and willing community involvement on a sustainable basis.

It has been argued that community financing favours the creation of health facilities for which there is high local demand but does not necessarily meet professionally perceived needs. However, in the present scheme the hospital had to raise 25% of the expenditure for highly subsidized care or free inpatient services, and therefore high-technology medicine, unless cost-effective, could not become the professional choice; 75% of funds were provided to the professionals, and consequently they did not have to accede to unreasonable local demands. Furthermore, the facilities are largely controlled by professionals and so excessive use can be prevented.

The insurance system was intended as a means of developing fairness in health care delivery and not of achieving self-reliance. Advocates of self-reliance should bear in mind that a good primary care programme demands adequate financial support, that poor people may not be able to contribute more than a very small proportion of their incomes for this purpose, and that a sensible balance has to be struck between funding from public and private sources. Health for all must be considered a social responsibility; financial burdens on a poor man’s resources are a social crime.

Empowerment is vital in the creation of a true people’s health service. In the present scheme it was found that the smallest viable participatory unit in a decentralized structure was the village council. Decisions should be taken by no less than about 75% of the members of such a council. A sound, cost-effective, social insurance scheme can take
clients away from an unregulated private sector.

In a national health insurance scheme, primary care should be accessible and affordable to the poor and should therefore be socially financed. Curative care should be free to the user. Social finance should be raised according to ability to pay, whether by direct or indirect taxation, and benefits should be offered according to need.

Empowerment of the people is essential if the public health sector is to be directly accountable to them; power flows through financial control and performance evaluation. The local public body in a decentralized system should be entrusted with these responsibilities.

It is necessary to regulate the private health industry, and investors. The private sector may be involved in hospital services on a fee-for-service basis. If outpatient services are opened up to the private sector, a system of universal medical insurance, financed by local government, should operate. Private medical insurance should not be allowed.

References


Length of survival and quality of life

Length of survival [of cancer patients] is frequently taken as the only measure of treatment success. Yet, how are a few months of additional life, involving treatment at high cost and with major adverse effects, to be evaluated? Given reliable guidance, physicians and patients can make more rational choices of approach. At present, however, physicians find it difficult to avoid the use of frequently ineffective anticancer treatments.