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Political decentralisation and community health insurance: protecting from cost of treatment-induced poverty

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Abstract
Access to affordable health care has been one of the prime objectives of all health systems and among the methods of financing household out-of-pocket payments at the point of delivery of service creates the maximum barriers to effective utilisation of health care especially by the lower income groups. Community financing at the local level garnering the scope of political decentralisation is a viable financing mechanism to address impoverishing effects of curative health payments. A pilot survey undertaken to elicit willingness to pay for community-based insurance program had seen substantial majority interested in the program and willing to be pay too.

Keywords: Political decentralisation, Community health insurance, Willingness to pay, CV Method, Impoverishment

Introduction
Catastrophic out-of-pocket expenditure for health care is one of the leading reasons for impoverishment among a large number of people in a number of national health systems. As per rough estimates, in India around 26 percent of the patients became "officially" poor due to the cost of treatment annually. Among the different ways of financing care, paying fees at the point of delivery of service creates the maximum barriers to access care especially for the low socio-economic groups. It is very difficult to make a positive impact on poverty, unless the mode of financing care in India changes from out-of-pocket to some other measure which pools risks of the individuals in a society. International agencies like World Health Organisation have identified that reducing catastrophic health care payments is one of the fundamental objectives of any modern health system (WHO 2000). When government withdraws or performs a less than optimal role than it is expected in financing of social services including health services, the burden of financing is shifted on to the individual households. In developing countries including India, financing is shifted on to the individual households. In developing countries including India, financing health care from general taxation is limited due to the financial constraints of the governments on the one hand and the low priority that these governments attach to health services. Though it is a fact that households bear the ultimate burden of financing almost all health care expenditure in a country, the manner in which the burden is distributed has implications for the overall welfare of different sections of population. For example, when health care is financed from direct taxes, the financing is said to be highly progressive and the poor will be benefited more than the rich, thereby redistributing the welfare from the rich to poor. However, when payment is based on ability to pay, the lower income groups are, by design, "crowded out" and create huge barriers to access care when household make payments with high opportunity costs in terms of loss of wages, borrowing at exorbitant rates of interest, distress selling of assets etc, it affects their economic security. Unlike other commodities, due to the large number of uncertainties associated with seeking care (uncertainty in incidence of illness its disappearance, cost of treatment etc) and those who bear the burden are suffering more, a general feeling is that society should collectively bear the burden are suffering more, a

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general feeling is that society should collectively bear the burden of financing such a catastrophe (Wagstaff 200). These kinds of conceptualizations might have been at work in the past leading to the creation of pre-payment and other collective risk pooling mechanisms.

Among them, community financing (CF) is being recognized as an important option to reduce catastrophic illness expenditure for people in rural areas and informal sector. In India, more than 90% of the general population and almost all the poor are not covered under any health insurance schemes. Their health care needs are met primarily through directed out-of-pocket expenditure. The burden of health care expenditure is unduly heavy for poor and other disadvantaged groups. Collective financing schemes provide the financial resources to promote better health and held diagnose, prevent, and treat known illness. It provides an opportunity to protect individuals and households against direct financial cost of illness when channeled through risk-sharing mechanisms. In India community financing experiments are limited and these programs are usually run by NGOs or non-profit organizations. These organizations rely on financing from various sources, including government, donor agencies, community and self-generated sources. They target primarily workers and families of informal sector and rural population and it contributes to the resources available for local health care systems, be it primary care, drugs, or hospital care. Government support makes the scheme more sustainable and pro-poor. Pro-poor orientation through exemption of premiums and subsidies are possible management allows social controls over the behavior of members and providers that mitigates moral hazard and adverse selection.

It is an unchallenged fact that CF methods reduce the financial burden faced by patients in seeking care. However, one major failure of almost all CF schemes has been the there happens frequent exclusion of the poorest due to their inability to pay. Without subsidies, resource mobilization is limited when everyone in the pool is poor. It is also unclear on what basis organizations establish fee levels and prepayment/insurance premiums. An estimation of the morbidity status, stage of demographic transition, the mortality conditions, the major risk factors etc need to be considered while organizing a health care financing scheme. However, in majority of the cases, this is rarely done due to either due to the non-availability of data or inaccurate data and data collection is costly etc. It is also seen that CF schemes are prone to adverse selection, moral hazard, and information asymmetry. Providers can have monopoly power during price and payment negotiations. There is also dissatisfaction with the delay between discharge from hospital and reimbursement and is longer especially for claimants who live in rural areas.

A government intervention at the local level can mitigate a good amount of problems faced by such schemes including exclusion of the poorest from enjoying the benefits of financial protection offered, countering adverse selection and cream skimming, targeting the population in a cost of effective manner and a substantial increase in the public confidence in the scheme. In the Kerala context, where decentralization has been acknowledged as a success in terms of participation of the people decision making, distribution of benefits, reduction in rate of poverty etc. The rural local government are better able to run such a scheme so that the financial burden facing the patients can be reduced to a great extent. Discussing the potential governments in the Kerala context forms the central idea of the paper. The enhance access and reducing inequality in health seeking through risk pooling and cross subsidization. It also brings to light the issues hovering around decentralization from a theoretical and empirical perspective. As the ability of a programme depends, in part, on the adequacy of finances, through a micro study on willingness-to-pay, the article discusses the modes operandi of such a financing scheme,

Methods

A review of literature was carried out to see the strength and downside of major community financing initiatives in developing countries including India. Since the proposed collective financing mechanism is implemented through a democratic decentralized governance structure. It has also surveyed briefly the experience of decentralization and its various across different countries and some states in India in specific. As the financial viability of such schemes depends in part, on the willingness of a certain population, it has used a willingness to participate and pay study as in input. The study has selected a rural local self- government in Thiruvananthapuram district. Majority of women are unemployed and nearly 30% of the families are officially poor. This is a panchayat which is average in many indicators of the state. It has taken a sample size of 50 households and involves around 250 including children. It has used the popular contingent valuation (CV) method to elicit the willingness to pay of the individuals. Among the different variants within the CV method, it has used a take-it-or-leave-it (TOILI) approach for arriving at an approximate value of the household's potential contribution (See Russell et al 1995; Smith 2003). The researcher has also conducted in-depth interviews with few chiefs of local self-government institutions to assess the potential issues in the management of such a scheme.

Community Financing: A Glance

A good amount of theoretical support for community facing (CF) has been provided by a few researches who drew theories from micro-finance, social capital and public finance, welfare economics, and social policies. (See Preker 2001 et al. for a clear exposition). While theories of micro-finance bring outs ability to low-income groups to save and social capital philosophy introduces the role of extended networks (vertical and horizontal)[1] in a community to financing medical care, the public economics theory assumes that problems like equity and efficiency. Principal-agency problems[2] are settled in case of community financing. The exponents of these theories, however, are not able to defend themselves against the critics' argument that in the name of self-support, these theories are actually justifying the withdrawal of state from the social and economic sphere.

Though not clearly defined community-financing schemes usually converge among a central feature of 'predominant

[1] Cooperation among similar communities (horizontal) and between different communities (vertical)

[2] The interests of the principal (beneficiaries) and agents (insurer) are converging towards the same objective through effective incentives and monitoring in CF schemes.

role of collective action in raising, pooling, allocating/purchasing, and/or supervising, the management of health financing arrangements" (Preker et al 2001). Another common character of these schemes has been that the beneficiaries are usually a population who do not have access to other forms of financial protection including free of charge public health services. A comprehensive review of such schemes by researchers (Preker et al 2001; Jakab and Krishnan 2001) brings out some interesting findings. Firstly, the different forms of community financing include community cost-sharing, community pre-payment or mutual health organization, community provider-provider based health insurance etc. Secondly, regarding resource mobilization, some CF methods are able to generate 12 to 51 percent of recurrent expenditure in many settings (Bennet et al 1998). Thirdly, there happened an increase in utilization as well as a reduction in out-of-spending on health care for the participants of CF schemes. However, it is not clear, to what extent, CF methods have been able to reduce the catastrophic levels of expenditure on participants. Fourthly, in majority of the CF schemes, social exclusion of the poorest is visible and also less cross-subsidization. In a recent study, some researchers even argued that community financing could not seen as a response to the ill-effects of economic reforms on health (Asfaw and von Braun 2004). Using household level data and double-bounded dichotomous choice contingent valuation method, the Ethiopian study (Asfaw and von Braun 2004) investigated the prospect of community health insurance schemes in mitigating the health shock effects of economic reforms and deregulations on the poor rural households. However, one major question here is whether the decline or present condition of public health services is a consequence of the economic reforms or the other way.

The history of community financing schemes in India reveals that they are mostly rural oriented as well as its ability to mobilize resources from a limited geographical spread (Gumber 2001). This phenomenon may perhaps be attributed to the non-availability and/or poor quality of public services in rural areas, absence of skilled and affordable private health care in these places which forces the people to seek some non-government alternatives. In India the contribution of some schemes amounts to around 14 percent of the recurrent expenses of the health facilities (Benne et al 1998). Since rich are not usually interested in the participation of community-based insurance plans due to their higher income status, cross subsidization between rich and poor, healthy and unhealthy, unemployed and productively employed is not happening in a number of instances with community insurance schemes. For the higher income groups, their participation is limited by their high-income status. Which is one of the most important protection mechanisms and they might have already been part of some voluntary insurance plans.

Political Decentralization

Decentralization, in its right spirit, is a mechanism capable of making widespread changes in the governance and can be an engine of change especially in rural areas. Though centralized decision-making is bureaucratic and inflexible, the national governments are better able to understand the international currents in the policy thinking. It is a fundamentally due to the fact that national and international policies are usually subject to intense debate than local issues. As decentralization involves a good amount of autonomy for decision making the local government, there is a possibility of differing pattern in policy formulation and implementation leading a dilution in resistance to a widely acknowledged 'bad' policy. It is better that these decentralized structures are working towards the achievement of a national goal and spirit while responding to the local needs. Researchers feel that though decentralization is argued at all levels of governance and decision-making, the evidence regarding positive impact of health systems' performance is scanty and is confined to some places (Seagall 2003; Nayar 2003). Though different levels of decentralization including deconcentration (shifting of workload from the center to the periphery, without giving decision-making powers), delegation (transfer of functions and responsibilities to para-statal organization for achieving improved efficiency), devolution (provision of resource control, responsibilities, policy formulation and implementation, etc (Nayar 2003) the present article is more concerned with political decentralization as worked out in the Kerala context in which the local population is empowered to discuss, decide and implement the programmes on their won and the maximum possible resources and other technical expertise would be provided by the higher level of government. Integration of democratic political structures in regional or sub-regional level decision - making is an essentially indispensable to realizing the potential advantages of decentralization (Segall 2003) which can be made a reality by responding to a given community's needs based on their responses. An effective democratic decentralization requires some of the important following elements like: (i) devolving adequate resources to lower levels of decision making, (ii) providing all levels of decision making with functional and financial autonomy, (iii) requiring that these funds are utilized as per a democratically decided and pre-specified development plan; and (iv) building capabilities to use resources devolved to each level effectively and transforming civic culture to enable democratic participation (Chandrasekhar 2004)

National level issues

Different grades of decentralization were attempted in a number of countries and results are mixed Nayar(2003) reports that Chinese decentralization had led to a market orientation within health services and market was able to penetrate into the system. Contrary to the experience of decentralization in many other countries which came as a part as well as response to the Structural Adjustment Programme(SAP), India has been talking of decentralization since independence. Though in many parts of the country some penetration of market is allowed through decentralized political process, we have a higher degree of political decentralization than managerial deconcentration. The history of decentralization in this part has witnessed a good number of ups and down and finally it took a definite shape and constitutional sanctity by the 73rd and the 74th Amendment to the Indian Constitution in 1993. The major factors which thwart an effective realization in the ideals of decentralization are the structural inadequacies, weakened political will especially at higher levels, ambiguity in the clarity of concepts, inadequate provision of resources, irregular elections, technical ineptitude dominance of politically and socially dominant

groups which 'crowd out' participation by lower social classes. Besides factionalism, corruption, inefficiency, nepotism etc played its supportive role in the process (Jafri 2001). It seems that panchayat raj is running through a crisis of trust in which it is not able to fulfill the aspirations and hopes people bestowed upon it.

Few words about Kerala-style decentralization

Kerala's tryst with decentralization has been projected as an alternative development model to the generic development and livelihood challenges faced by the poor countries from the onslaught of globalization. The paper, at the first instance discusses the issue in brief before passing on to the technicalities of implementation of the particular health care financing programme. There exists a good amount of conceptual ambiguity as well as misunderstanding regarding the concept of decentralization as perceived by the scholars especially in the recent context of an ideological imbroglio happened here. The major distinction between Kerala's decentralisation process and World Bank's decentralisation policy is summed up by Patnaik (2004) in these words: "While the "decentralisation" agenda of the Left is a means of carrying class-struggle forward, of buttressing the class-strength if the rural poor by developing institutions where they can, in principle assert themselves directly and hence more effectively, The "decentralisation" promoted by the imperialist agencies has precisely the opposite objective, of blending class-struggle, of encouraging a scenario of "obedient-and-supplicant-villagers-being-patronized-by-NGOs", and of substituting the concepts of the "Rights" of the people by the concept of "Self-Help". The decentralisation in Kerala was also seen as a new development paradigm in which participatory developmentalism to prevail over democratic pressure politics. Kerala's decentralisation in counted different from other variants practiced elsewhere basically on many counts (Issac 2000). Here the decentralisation process is taken off like a mass movement and not a technical legislative exercise. It also strictly followed a pure-bottom-to-top approach and not the other way. It is also noted that neo-liberal conception of decentralisation believes that market is the best mechanism functioning on the basis of decentralisation, because consumers are independent entities that take decision at the lowest level. World Bank decentralization is essentially an attempt at withdrawal of the state from the social sector, while the aim of decentralized planning was not a withdrawal but greater accountability of an activist state (Patnaik 2004). With regard to the participation of lower socio-economic groups, Kerala has a comparative advantage over many other States where due to the right implementation of land reforms. With regard to health sector, an analysis of the development reports prepared by few panchayats in the State showed that issues related to health care especially preventive care had been ranked as one of the prominent priorities for the local population (Nayar 2001).

However, for the last few years the major hurdles which prevent an effective undertaking of decentralization process in the State include the timing of allocation of funds, the conflict of interests among the people, politicians and bureaucracy, inability of the local political leadership to convince the government health services professionals at the policy formulation level, non-cooperation from the latter, absence of clarity in the roles of panchayat in the implementation of state-level and central government programmes. Bureaucracy at the top-level usually resist any erosion in the degree of power they enjoy which is still continuing in the state. Since panchayats were given a huge sum (one and half crores per annum per panchayat) (Kannan 2000) compared to their expectations, their technical incapability and other bottlenecks prevented them from utilizing fully leading to a huge unspent amount getting lapsed.

The Collective Financing Scheme

Usually, CF methods assume added relevance in the context of absence of any other form of financial protection including tax-based publicly provided health services. However, in the Kerala context, public health services are ranked as one of the most equitable and efficient in the country (Mahal et al 2000). However, due to the declining public allocation for health care, the private out-of-pocket expenses for treatment is rising at very high rates in both public as well as private, and cost per episode of treatment is also among one of the highest in the country. Besides communicable diseases, growth of non-communicable illnesses and injuries at a faster rate poses new problems in the State in terms of resource requirements for the health system, and issues like accessibility, cost effectiveness of treatment etc are also relevant.

As part of ensuring health security to a good proportion of the people, some of the local-self-governments in rural areas started designing a collective financing scheme in which a fixed amount of money (Rs. 25 per person per month, Rs. 20 for women and children) has to be contributed by each individual households and in return, these participant households may get financial protection against the cost of treatment up to a certain limit (Rs. 30000)[3]. The scheme follows the premium pattern of the Central government's new public insurance scheme in which for a family of five, the premium is Rs. 548 per year and Rs. 730 per annum for a household of seven. It has a special provision that those families who are included in the below poverty line (BPL) category need not pay the premium, but just need to be a part of it, while they will also receive the same kind of benefits as other paying participants. The benefits package includes all inpatient care, accidents and emergencies, and costly ambulatory care and cost of transport by ambulance. The patients can get admitted in some identified hospitals including government ones and a special general physician at the local panchayat will be functioning as a 'gatekeeper' and decides the appropriate level of care.

One of the conceptual problems of using willingness to pay (WTP) criterion for designing a policy is that it ignores the preferences of the population with less ability to pay (ATP). In order to avoid the loss of welfare or absence of welfare to the poor, the government compensates by fully bearing the poor households' premium. Though such a component may affect the economic viability of the scheme, considering the problem of "social exclusion" prevalent in most of the community financing schemes, they are included.

Adverse selection has been a perennial problem in all

[3] One US dollar (1) is equal to around 46 Indian rupees in 2004, Jan

voluntary protection schemes including community financing in which high-risk individuals have a more than proportionate propensity to join the schemes while low-risk individuals try to keep away from the pool. Since insurance services work on the law of averages, a high proportion of high-risk individuals leads to the insolvency of the project itself. Besides, there is a possibility of discrimination in the allocation of health care resources within a household based on age, gender, and other roles. To avoid such problems, the household is taken as the minimum unit of membership in the scheme and not individual members within a household.

Results of the willingness to pay study

The primary survey points out that the 54% of families are voluntarily willing to contribute to the CF scheme. Thirty four percent of the study population is not willing to co-operate with the scheme. A 12% of families were willing to participate but due to their inability to pay, they cannot pay the premium. It is seen that those who are already covered by some form of insurance like Employee State Insurance Scheme (ESIS), or any other voluntary medical insurance they have shown less willingness to pay compared to unprotected, but belong to the same economic category. Those people who have incurred comparatively higher health care expenses were willing to pay more than the rest. This finding is in harmony with an earlier study on willingness to pay for a community-based health insurance scheme in Burkina Faso (Dong et al 2003).

Discussion and Policy Implications

A brief analysis of the experience of community-based insurance schemes in many developing countries shows that if organized well through efficient administration and the cross subsidization, it has got the potential to reduce the ill health related poverty of the patients and their households. The analysis focused more on Kerala, a state in India, which has been noted globally for its higher human development indicators despite poor performance in terms of economic growth, is now facing scars in the human development front as reflected by the slow progress in its indicators. The health system is showing high levels of technical and economic inefficiency due to the fast-declining public budget for health care, in part and treatment from the unregulated private sector is getting beyond the hands of a large number of economically and politically weaker sections including women. In the context of Kerala, where the atmosphere for introduction of such a scheme shows good potential through a decentralized administrative and political system. The state, in recent times, introduced political decentralization and local self-governments (LSGs) are given enormous power in terms of responsibilities functioning and finance in all sectors including health care.

The present method has in it elements of both social insurance as well as community financing. For example, like community insurance the participation is voluntary in nature, but like unlike community financing socially vulnerable groups are included in the design. Even though maternal and child health has been identified as an issue of adverse selection because of its certainty in occurrence, considering the utilization of health services by women, maternal and child health care has been included in the benefit package design. Another major limitation of the programme as envisaged here is that of the low amount of coverage for the treatment of some diseases which require costly medical interventions. For example, the maximum financial support offered by the scheme is Rs. 30000/- per annum, while cost of treatment for some treatment requires many times more than that. However, from the point of view of financial sustainability of the programme and considering the cost of treatment of majority of the clinical interventions in our setting, we assume that the financial catastrophe facing the patient can be reduced.

One important factor to be kept in mind when analyzing the role of voluntary health insurance including widely used policies of Mediclaim, ESIS, SEWA etc in the country, they are able to cover only 55 to 67 pe4rcent of the total hospitalization expenses and, on average, only 10 to 20 percent of the total annual out-of-pocket expenditure on health care of the members (Gumber 2000). The role played by these initiatives are limited because unlike the government health services which, even with poor quality, is able to offer a wide variety of services from preventive through curative care while the voluntary sector packages cover only a fraction of the total health care needs. In other words, most of the schemes serve not only a small segment of the population and but their coverage of services is also limited. In a study, Gumber (2001) finds that community-financing schemes provided less financial protection against cost of treatment than social insurance scheme (ESIS). Further, it is seen that community plan as well as Medicare (an insurance scheme of General Insurance Company) were less able to reduce household expenditure on health care basically because of the fact that they covered only hospitalization while an individual's major expenses are incurred for meeting ambulatory care needs. This is a major limitation of all voluntary protection schemes and it is a necessary evil when considering the viability of insurance plans. However, from a patient's view of utilization of care, a reliable method to provide care at the lowest cost at all times is that of by the free public health care delivery and financing.

It is often seen that the introduction ads well as promotion of voluntary non-governmental efforts like community financing of medical care, education, pricing water etc as a deliberate move to trim down the role of state and shift the burden of financing the basic services on the shoulders of the households. Such experiences are borne by the fact that when user charges are introduced, it is followed by a cut in allocation for health facilities which further accentuates the vulnerability of households. It is also to be noted that temporary financing arrangements like community financing should not be seen as means to shift the burden of financing medical care from the public sector to private household sector nor should be a measure to transfer the burden to poor households from the rich by means of reducing the role of tax-based financing of medical care.

Though it is a fact that treatment of population based on these kinds of programmes adds on to the fragmentation of health services. However, fragmentation in health care services is necessary evil in the context of programmes of this nature; and they are to be promoted as long as it contributes positively to increasing access and improved financial protection for the participants. In the long-run there is no perfect alternative to an independent and government-led financing system which works on the principle of reducing the emphasis on curative medical care

and increasing the role of preventive and promotive health expenses. In the other words, community health insurance cannot be seen as a substitute to an effective public health service. For, the experience of those countries which promoted private health services realised that competition among them leads to escalation of costs in health care and reduction in the effectiveness of health spending. As the private sector health services do not have the required incentive to invest in preventive and promotive components of care, they mostly focus on the curative and palliative care. In other words, viewed in terms of marker expansion, preventive care which is less costly reduces the size of the medical care market in future. However, the government health services based on an effective reimbursement mechanism provides the physician to emphasize preventive care, which in the long run reduces the pressure on health services. The present programme also needs more government allocation for health care so that the local governments can exclude the lower income groups from requirements of pre-payments. The treatments, which are quite elective as well as which do not pose threat to the life of the individual if left untreated, could be charged a minimum cost price.

One of the major problems policy makers have been trapped in for long is the issue of targeting of benefits of many programmes especially when the policy planners want to0 distribute some benefits/costs of a policy decision among different ranks of the population. The question of targeting/rationing arises when resources are scarce and the method of intended differential treatment fails partially/fully to deliver. The local governments are better able to target the needy or rich and poor population due to the lower amount of information asymmetry they hold with regard to the socio-economic levels of a given population. In this present study setting, local governments can identify poor and rich as all adult members are supposed to attend the gram sabha meeting (ward council) at least twice a year. Since a good amount of secondary and tertiary level government facilities satisfy the criteria (like certain number of beds, diagnostic facilities, pay wards etc) for giving inpatient and emergency treatments, the hospitals can recover part of the cost of treatment and by admitting the patients from the collective financing schemes. Thus the public hospitals can channelize these resources for enhancing the quality of care.

Terms like decentralization, community financing etc are usually given an idealized and romanticized flavor as if these can settle all the dusts in the area of governance and health financing. It is to be understood that majority of our so-called communities are heterogeneous entities and stratified along different dimensions and their interests may not coincide. Segall (2003) cautions that these organizations are to be guarded against the possible domination of 'community leaders' and active measures are required to incorporate the voice of the weaker sections. It is also a fact that decentralization can have a good proportion of non-governmental participation, but from sustainability point of view public services should have a lead role (Segall 2003).

The community financing has got some potential to play a role in health system of Kerala where a good amount of population is below the poverty line and have no protection against catastrophic illness costs. Although income is a key constraint to participation by the poorest of the poor, they are often willing to participate if their contributions are supplemented by a government subsidy and an access to quality services. Financial and technical assistance from the government to strengthen the CF. More research is needed to understand community health financing in India in its ability to be a viable option for financing health care.

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